

ENGAGING MEN AND BOYS IN GENDER EQUALITY AND HEALTH

A global toolkit for action



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UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.



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Founded in 1997, Promundo is a non-profit Brazilian organization focused on promoting gender equity and preventing violence against women, children and youth.



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MenEngage is a global alliance of NGOs and UN agencies that seek to engage boys and men to achieve gender equality.



Foreword

WHY IS A TOOLKIT ON ENGAGING MEN AND BOYS NECESSARY?

Despite the increasing recognition of the important role that men and boys play in family planning and sexual and reproductive health, HIV/STI prevention, Gender-based Violence, maternal health and in childcare, they are still rarely engaged in health policies and programmes.

In many cases, this is due to doubts about how to most appropriately and effectively integrate them in health promotion as well as lingering scepticism regarding whether men and boys really can change their behaviour. This toolkit serves to articulate and reinforce the benefits of working with men and boys and provide practical strategies for doing so in ways that address the underlying gender norms which most often influence their health-related attitudes and behaviours.

WHAT DOES THIS TOOLKIT CONTAIN?

The toolkit presents conceptual and practical information on engaging men and boys in promoting gender equality and health. Specific topics include sexual and reproductive health, maternal, newborn and child health, fatherhood, HIV and AIDS prevention, care and support, and GBV prevention. In addition to laying out numerous examples of programmes that have effectively addressed these challenges, the toolkit provides guidance on advocacy, needs-assessment, monitoring and evaluation related to efforts to engage men and boys.

HOW WAS THE TOOLKIT DEVELOPED?

The toolkit was developed by Promundo with the input and guidance of UNFPA and MenEngage, an alliance of NGOs that work with men and boys to promote gender equality. MenEngage member organizations along with UNFPA and WHO representatives, participated in a three-day consultation to provide experiences and recommendations for the development of the toolkit. The participants in the consultation were all experts in the fields of involving men in Sexual and Reproductive Health (SRH), HIV and AIDS, Gender-based Violence (GBV), Fatherhood, and Maternal, Newborn and Child Health (MNCH) and their contributions to this consultation were fully utilized in the development of the toolkit. These

same organizations (MenEngage members, UNFPA and WHO representatives) participated in the subsequent review and editing of the toolkit and the approval of the final version.

WHO IS IT FOR?

This toolkit is designed for programme planners, health providers, peer educators, advocates and others who work on issues related to gender equality, SRH, MNCH, HIV and AIDS prevention, care and support, and GBV prevention.

HOW SHOULD IT BE USED?

For the sake of organizational clarity this toolkit is separated into different modules or chapters which can be consulted together or separately. Suggested topics were agreed upon at the UNFPA consultation in Salzburg that was held to specifically inform the development of this toolkit¹. Each module is accompanied with “tools” for further guidance and the hands-on application of concepts and strategies. These tools are located at the back of the document and are organized and colour-coded to match the specific chapter to which they refer.

Although most of the chapters of this toolkit can be read individually, the authors recommend that the user first go over the Introduction thoroughly because it provides an overview of Gender Transformative Programming discussed that is throughout the toolkit.

Additionally, most of the tools included in the Introduction can be utilized in projects targeting any of the specific topics mentioned above. After perusing the Introduction, readers can decide whether they would like to read the full toolkit or to concentrate on topic-specific sections that are most relevant for their work. The chapters about advocacy and evaluation are relevant to all of the topics covered in the toolkit.

Finally, it is important to keep in mind that there is no single set of strategies and tools that serve to engage men and boys. The ones outlined here serve mainly as inspiration and should always be adapted according to local needs and experiences. Although the user may have a specific thematic focus, it is worthwhile to go over the toolkit in its entirety to gain an understanding of how programmes can support integrated efforts.

¹ In December 2007, experts gathered in Salzburg, Austria at a technical consultation hosted by UNFPA, WHO and Instituto Promundo to review programmes and policies designed to engage men and boys in the promotion of gender equality and health equity. The results form the basis of this toolkit.

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Introduction



WHY GENDER IS ALSO ABOUT MEN AND BOYS

Gender—the socially constructed roles, identities and attributes of men and women—is now widely recognized as integral to understanding and addressing behaviours and vulnerabilities. The reality is that men and women are unequal in the context of intimate relationships, households, communities and indeed, society as a whole. The gender-related attitudes expressed by men and boys directly affect the health and well-being of women and girls. These attitudes include, for example, beliefs that men should be the presumed head of the household—particularly when it comes to making decisions. In many cases, fathers, husbands, partners, and other men, may have the power to decide to withhold income for a woman's healthcare needs, refuse to allow her to use contraceptives or use them himself (including condoms) and limit freedom of movement and association. Many men may also believe that they are not responsible for caring for children or doing domestic chores, thus increasing the workload of women and girls. Also, many men may believe that they have the right to expect sex whenever they want, particularly from their wives, girlfriends and sexual partners, and that it is permissible to resort to violence if the woman refuses. This section will discuss in more detail what it means for programmes to address gender and to engage men in questioning and challenging the inequalities between men and women.

While evidence has confirmed that working with men and boys to challenge gender inequities can have a positive impact on the health and well-being of women and girls, it is important to also recognize the importance of addressing the links between gender and men's and boys' own health and social vulnerabilities. For many years, the conventional wisdom was that men and boys were doing

well and had fewer needs than women and girls; that they are difficult to work with, aggressive, and do not care about their health. Men and boys are often seen as the perpetrators of violence—violence against women, against other men, and against themselves—without stopping to understand how the socialization of boys and men encourages this violence. In fact, in some settings, men and boys are lagging behind women and girls in terms of several important health and social indicators. For example, men commit suicide at 3.6 times the rate of women and men also drink more alcohol and are more likely to die from alcohol-related disorders (Bertolote and Fleischmann, 2002; WHO, 2004). In sum, new research and perspectives are calling for a more careful understanding of how men and boys are socialized, how gender norms shape their own health and development, and how programmes and policies can best address their needs, in conjunction with the needs of women and girls.

Finally, it is important to address the common concern of whether investing in work with men and boys will divert scarce resources from work with women and girls. Because the latter still bear the greatest burden of gender inequality and SRH morbidity and mortality, women and girls must continue to be the priority with respect to international and national health and development agendas. At the same time, however, it is important to keep in mind that many female vulnerabilities are rooted in rigid gender roles and norms which often give men a disproportionate share of decision-making and control of resources. It is therefore important to emphasize that promoting women's empowerment is not only a matter of directing resources to women and girls, but, in a broader sense, investing resources to promote changes in the power dynamics which influence women's lives

and relationships (Kaufman, 2003). In other words, if the problem lies with male behaviour then men and boys need to be engaged.

What does this look like in practice? Men can facilitate not only the opportunity of the women and girls in their lives to access quality healthcare but their own as well. Men and boys can be mobilized to share responsibilities for family planning, domestic work and childcare, and to avoid resorting to violence against women, girls and each other. They can also encourage other men to do the same. Thus, money spent on well-designed health programmes, which seek to promote more gender-equitable behaviours among men and boys should be viewed as investment in a larger process of gender transformation which benefits women and girls, as well as men and boys.

This section discusses what it means to incorporate a gender perspective into work with men and boys. More specifically it explores guiding principles and strategies for the most common types of programme interventions that seek to transform the perception of what it means to be a male or female.

BOX 1

WHY WORK WITH MEN AND BOYS?

Numerous UN-sponsored meetings and statements have affirmed the need to engage men and boys^{2,3} to achieve gender equality. These statements include the Programme of Action of the 1994 International Conference on Population and Development (ICPD), and the recommendations of the 48th Session of the Commission on the Status of Women (CSW).

The ICPD Programme of Action calls for the innovative and comprehensive engagement of men and boys towards the achievement of gender equality and, most importantly, does not present men and boys as “obstacles” but as allies. In 1995, the Fourth World Conference of Women Programme of Action in Beijing reaffirmed this emphasis.

At the 48th session of the CSW governments from around the world made a formal commitment to implement a range of actions to involve men and boys towards the achievement of gender equality.

In spite of the increasing international attention and examples of interventions targeting men and boys, a brief review of a number of health indicators suggests that much remains to be done:

Family Planning and Sexual and Reproductive Health: Seventy-four per cent of contraceptives used worldwide are female-based. Despite some progress with persuading men to use condoms or to support

women to make their own contraceptive choices, it is women who continue to bear most of the responsibility for family planning worldwide (UN Commission on the Status of Women, 2007).

Maternal Mortality: The World Health Organization (WHO) estimates that approximately 600,000 women die in childbirth each year. The majority of these deaths are entirely preventable. Even though it is men who often control access to health services, very little is being done to work with them to reduce maternal and infant mortality. (UN Commission on the Status of Women, 2007).

Fatherhood and the Care and Raising of Children: Worldwide, women spend three-to four-times the amount of time rearing children than men do—even in those countries where women are working outside the home in numbers close to, or equal to that of men (UN Commission on the Status of Women, 2007).

GBV: According to numerous household surveys, including the WHO sponsored multi-country study, between 30 and 50 per cent of women worldwide have suffered physical violence at least once at the hands of a male partner (UN Commission on the Status of Women, 2007 and WHO Multi-country Study on Women's Health and Domestic Violence Against Women⁴).

HIV and AIDS: Within the context of intimate relationships, women are also less likely to be able to negotiate condom use and are more likely to experience coerced or forced sex. Women are also far more likely to assume the responsibility of caring for AIDS patients and orphans. On the other hand, men are also vulnerable to HIV infection owing to gender attitudes that discourage them from using condoms or being tested for HIV (Spink, 2009), while, at the same time, encouraging concurrent relationships with multiple partners.

BOX 2

CULTURE, GENDER AND HUMAN RIGHTS

Neither gender equality nor the empowerment of women will ever be realized unless programmes and policies are also imbedded in the local context and designed and implemented with cultural sensitivity. As emphasized in the ICPD Programme of Action, “the establishment of common ground, with full respect for the various religious and ethical values and cultural backgrounds” is key to promoting gender equality and health. To this end, UNFPA integrates three elements to its approach to programming:

2 'Boys' refers to males up to 19 years of age. However, most of the programming experiences in this publication that target boys work mainly with adolescents and not young boys under 14 years of age. It should be noted that more programming and research needs to occur with promoting gender equality among boys.

3 'Adolescents' are generally defined as those aged 10-19 and 'young people' as those aged 15-24.

Human rights: All human beings are entitled to equal rights and protections;

Gender mainstreaming: is a strategic response to the widespread denial of the human rights of women;

Cultural sensitivity: approaches involve communities in supporting human rights regardless of the cultural context.

SOURCE: UNFPA. UNDERSTANDING CULTURE, GENDER AND HUMAN RIGHTS. [HTTP://WWW.UNFPA.ORG/CULTURE/RIGHTS.HTM](http://www.unfpa.org/culture/rights.htm), ACCESSED JUNE 2008

BOX 3

SOME DEFINITIONS

Sex refers to the biological characteristics, which define humans as female or male⁴.

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identity and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction, as experienced throughout our lives. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors⁵.

Sexual Orientation refers to an individual's capacity for emotional and sexual attraction to, and intimate and sexual relations with individuals of a different gender or the same gender, or more than one gender⁷.

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Gender refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed (in other words, learned through socialization processes)⁸.

Gender Identity refers to a person's innate, deeply felt psychological identification as man or woman, which may or may not correspond to the person's physiology or designated sex at birth⁹.

Gender Roles refer to the attitudes and behaviours that society considers appropriate for men and women on the basis of their biological sex¹⁰.

Gender Equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men are the same but that women's and men's rights, responsibilities and opportunities should not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration—recognizing the diversity of different groups of women and men. Gender equality is not a “women's issue” but should concern and fully engage men as well as women. Equality between women and men is a human rights issue and as a precondition for, and indicator of, sustainable people-centered development¹¹.

Masculinities refer to the socially constructed perceptions of being a man and implies that there are many different and changing definitions of manhood and of how men are expected to behave.

Patriarchy refers to historical power imbalances and cultural practices and systems that confer power and offer men and boys more social and material benefits than women and girls. (United Nations Division for the Advancement of Women, 2003).

(THE TOOL “LEARNING ABOUT GENDER” SHOWS HOW TO USE SIMPLE LANGUAGE TO EXPLAIN THE DIFFERENCE BETWEEN GENDER AND SEX.)

4 Available for download at http://www.who.int/gender/violence/who_multicountry_study/en/

5 WHO Technical Consultation on Sexual Health, January 2002

6 Ibid

7 Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity as cited in United Nations High Commissioner for Refugees (UNHCR) Protection Policy and Legal Advice Section Division of International Protection Services Geneva, 21 November 2008

8 OSAGI, Gender Mainstreaming: Strategy for Promoting Gender Equality Document, August 2001.

9 Taken from Human Rights Campaign - http://www.hrc.org/issues/gender_identity_terms_definitions.asp

10 WHO Technical Consultation on Sexual Health, January 2002

11 Ibid

WHAT IS GENDER TRANSFORMATIVE PROGRAMMING?

Programmes can be classified according to those that reinforce gender inequalities (i.e. gender exploitative programming) to those that aim to transform underlying gender inequalities (i.e. gender transformative, see Box 4). In between lies a continuum that also includes gender-sensitive programming—those programmes that recognize the specific needs and realities of men and women but do not necessarily seek to change or influence gender relations (see Box 4).

Gender transformative programming seeks to challenge and transform rigid gender norms and relations. A recent review confirmed that programmes which applied a gender transformative approach were more likely to lead to changes in the attitudes and behaviours (including health behaviour) of men and boys than those that did not make an explicit attempt to address and challenge gender norms (see Box 5).

Gender-transformative programming generally entails moving beyond the individual level to also address the interpersonal, socio-cultural, structural and community factors that influence gender-related attitudes and behaviours (Gupta, 2000; Gupta et al., 2002). Gender-transformative programming might include, for example, group workshops with young men that are designed to promote critical reflections about gender and socialization while, at the same time, undertaking a media campaign designed to transform how their parents, peers and others in the community also perceive gendered social norms. In essence, gender transformative programming seeks to address the various contextual influences on male behaviours rather than just a specific behaviour itself.

Finally, it is important to recognize that gender-transformative programming is not always applicable and/or feasible and that many health-related efforts may instead aim for gender-sensitivity. Indeed, when designed and implemented well, gender-sensitive programmes can also be effective in promoting changes in men's health-related attitudes and behaviours. The toolkit therefore includes a combination of gender-transformative as well as gender-sensitive programmes (for easy reference, classifications have been included in each of the programme case studies).

BOX 4

THE GENDER PROGRAMMING CONTINUUM

The gender programming continuum is comprised of four categories. These indicate the degree to which programmes address – or fail to address – gender-related norms.

Gender exploitative programmes use and reinforce gender inequalities in the pursuit of health and demographic goals. This is a negative level of programming that should be avoided.

Gender neutral programmes distinguish little between the needs of men and women, neither reinforcing nor questioning gender roles.

Gender sensitive programmes recognize the specific needs and realities of men and women based on the social construction of gender roles, but do not necessarily seek to change or influence gender roles and relations.

Gender transformative programmes seek to transform gender relations through critical reflection and the questioning of individual attitudes, institutional practices and broader social norms that create and reinforce gender inequalities and vulnerabilities.

Evidence indicates that gender-transformative programmes are the most effective and are therefore presented here as the “gold standard” for work with men and boys (see Box 5). At the same time, we also recognize the important role gender sensitive programming can play in engaging men and boys, and have included several examples of such programmes in the toolkit.

(ADAPTED FROM WORK BY GEETA RAO GUPTA (GUPTA, 2000; GUPTA ET AL., 2002)

BOX 5

ENGAGING MEN AND BOYS TO TRANSFORM GENDER-BASED HEALTH INEQUITIES: IS THERE EVIDENCE OF IMPACT?

A WHO-Promundo literature review assessed the impact of programmes, which seek to engage men and boys in health and gender equality, including those that focus on SRH, HIV prevention, and GBV (Barker et al., 2007). The evaluators reviewed programmes and ranked them according to overall effectiveness, as determined by the rigourness of the evaluation design and the level of measured impact.

The review revealed that well-designed programmes do indeed lead to attitude and behaviour change. Moreover, the review also found that gender-transformative programmes—those which included deliberate discussions of gender and masculinities, and clear efforts to transform such gender norms—seem to be more effective than programmes which merely acknowledge or even ignore gender norms and roles (gender sensitive or gender neutral programmes).

The review also found that integrated and community mobilization programmes are more effective when it comes to promoting behavioural change than single-strategy or individual-focused efforts. This highlights the importance of reaching beyond the individual level to the social context in which men and boys live.

In conclusion, the review pointed to three major challenges or gaps in the field:

Many programmes that focus on men and boys lack the necessary resources and technical skills to develop, implement and evaluate conceptually and theoretically grounded interventions;

Funding has often been fragmented and short-term;

A favourable political and societal environment to support the engagement of men and boys in gender equality is lacking.

In practice, these challenges are interlinked. Building the technical capacity of programmes to carry out and evaluate interventions helps to establish the evidence base necessary to leverage the political and social buy-in necessary to boost funding. This is necessary to strengthen and sustain programme efforts.

To this end, programme planners, advocates, donors, governments, other stakeholders, indeed, men and boys themselves, need to collaborate to create an enabling environment. This in turn will lead to positive changes in gender norms and improved health outcomes for everyone—women, girls, men and boys.

THE ECOLOGICAL MODEL: WORKING AT MULTIPLE LEVELS TO TRANSFORM GENDER

Gender transformative programming means recognizing and addressing the individual, institutional and cultural dynamics that influence the behaviours and vulnerabilities of men and women. An “ecological model” can be a useful tool for mapping out these multiple and ever-changing inter-relationships and identifying entry points for gender transformative programming. The ecological model illustrates the importance of working not only with individuals, but also with diverse and interconnected social groups, systems, and structures that influence gender norms and the behaviour of men and women.

While it is unreasonable to expect that any single organization, movement or programme can span all of these influences—the ecological model can help to contextualize a programme’s possible impact. It can also identify those factors that promote (or constrain) its potential for success and opportunities for linking and collaborating with other programmes.

This toolkit discusses programme strategies that work within and across these different levels: group education with individuals, peers and families; strengthening of health and social services; community outreach and mobilization; and advocacy campaigns designed to change broader social and political norms and practices. These include, but are not limited to, transforming legal, political and economic structures.

Each of these types of programme strategies should be, in turn, viewed as only one piece of a broader and more comprehensive approach. For example, reflections and messages promoting group education efforts should be complemented and reinforced by strategies at other levels—from increasing the preparedness of local services to engaging men and boys to undertaking community education and national advocacy initiatives.

Three types of programme strategies designed to engage men and boys are: Group Education, Campaigns & Community Mobilization, and Health & Social Services. These three types of programme strategies help to address the different levels mentioned in the ecological model. In the subsequent thematic sections of the toolkit, more specific examples are provided regarding the use of these different strategies to engage men and boys. Also included are sections about how to monitor and evaluate programmes, as well as how to use advocacy and policy to reinforce and expand the reach and impact of successful strategies.

BOX 6**THE ECOLOGICAL MODEL: WORKING AT MULTIPLE LEVELS
TO TRANSFORM GENDER NORMS¹²**

STRENGTHENING INDIVIDUAL KNOWLEDGE AND SKILLS	Helping men and boys to understand how gender and social norms influence their partners and families, and develop the skills necessary to carry out healthier and more equitable behaviours.
CREATING SUPPORTIVE PEER AND FAMILY STRUCTURES	Educating peers and family members about the benefits of more gender-equitable behaviours and relationships and the ways they can support each other to promote gender equality and health among their families and peer groups.
STRENGTHENING SOCIAL INSTITUTIONS BY EDUCATING HEALTH AND SOCIAL SERVICE PROVIDERS AND TEACHERS	Educating health, education and other service providers about the importance of addressing gender norms with men and boys in clinics, schools and other health service settings. In the context of health services, providers should be trained to address men's own health-care needs as well as to engage them in supporting their partners' access to health information and services. Likewise, teachers should be made aware of how schools can shape and reinforce gender norms and be offered access to gender-sensitive curricular materials.
MOBILIZING COMMUNITY MEMBERS	Educating community members and groups about healthier and more equitable behaviours for men and women and how to support individuals to take actions that promote health and safety.
CHANGING ORGANIZATIONAL PRACTICES	Adopting policies, procedures and organizational practices that support efforts to increase male engagement.
INFLUENCING POLICY LEGISLATION AT THE SOCIETAL LEVEL	Developing laws and policies that provide sanctions for gender inequality and reinforcement for positive male engagement.

GROUP EDUCATION

Group education involves creating dynamic discussion spaces in which men and boys can reflect critically about gender norms, relationships, and health, as well as 'rehearse' the skills and abilities necessary to reduce risk behaviours and act in more equitable ways. Men and boys often experiment with and rehearse masculine roles and behaviours in peer groups. Thus, it stands to reason that group educational learning provides the most appropriate environment through which to discuss and question how gender is socially constructed. It also provides an opportunity to rehearse more equitable models of what it is to be a man or a boy.

Group education sessions should be based on a structured curriculum that is organized, flexible, and culturally appropriate to the target group of men and boys. The curriculum should include activities that complement each other and reinforce connections between the themes explored and real life. This could most effectively be accomplished through participatory activities such as role playing, discussions of case studies or "what-if" activities (examples of "what would you do" in this situation scenarios). Participatory activities such as role playing and debates also provide men and boys with a fun way to explore problems and scenarios they might not feel comfortable discussing in real life. It also

allows them to "try on" perspectives that they might not normally consider. For example, men and boys assuming the role of women and girls would help them better understand what women and girls contend with.

The goal of group education session should not be to "tell" men and boys how they should or should not behave, but rather, to encourage them to question and analyze their own experiences and to identify the factors that influence their decision-making and vulnerability. (Tools—"Act Like a Man, Act Like a Woman" and "Persons and Things" both address the social constructions of gender and power within relationships with group audiences.)

In addition to providing a space for critical reflection on a variety of different issues, group education sessions should also provide accurate and unbiased information and skills-building on relevant topics. It is important that information be presented in ways that make it personally meaningful to men and boys and that it helps to empower them to lead healthier lives and pursue more equal relationships.

Participatory activities such as role-playing can also enable men and boys to develop and practice various skills, such as negotiation and decision-making. Fatherhood-

¹² EngenderHealth MAP Manual / Adapted from the work of the Prevention Institute, Oakland, CA, USA focusing on violence prevention, including intimate partner violence.

Only a limited amount of research and programme experiences address the questions of masculinities, gender and health as they relate to persons with disabilities. Some men and boys with disabilities possess limited physical capacity, which means they must depend on others for some or all of their care and economic well-being. As a result, others, and indeed they themselves, may judge them as being "less masculine". The inability to fulfil male gender stereotypes of strength, virility and independence may in

turn influence their sense of worth and push them into situations of risk or vulnerability.

These kinds of considerations underlie the urgency of more research and programmes on working with men and boys living with disabilities. It is critical that such efforts respect the needs and human rights of those affected and they draw from guidelines¹³ on the issue as well as the Convention on the Rights of Persons with Disabilities

focused interventions, for example, can include sessions that involve practice changing diapers and/or how to give a bath. Other examples of important skills-based sessions include how to talk with a partner about safe sex; how to use a condom; how to express one's feelings without being violent; and, how to manage anger and resolve conflicts in the context of intimate relationships.

Skilled facilitators are a crucial part of the group education process. Their role is to create an open and respectful environment, one in which men and boys can feel comfortable enough to share and learn from their own experiences and question deeply held views about manhood and gender without being censured or ridiculed by peers. It is critical that the facilitator possess a basic grounding of the concepts of "masculinities" and the different social and health themes to be addressed during the sessions. As part of his/her training, the facilitator should also undergo a process of self-reflection regarding his/her own experiences and struggles around gender, masculinity and femininity. This will enable him/her to discuss these topics in a relaxed and open manner. Facilitators also need to be consistently sensitive and responsive to participants and approach activities with as little bias as possible. The facilitator should remain alert to the possibility that individual participants may need specific attention and, in some cases, referral to professional services or counselling (Tool: "Tips for Facilitators" provides more information about facilitation skills). The facilitator should also have the skills necessary to promote respect between participants, as well as to manage conflicts that may arise.

A common question regarding facilitators is whether men facilitators are more appropriate and effective than women facilitators. Experience has shown that while male or female facilitators may offer different benefits, it is not necessarily inherently better to have a male facilitator. Although men might be perceived as more persuasive and easier to confide in—in addition to serving

as a positive role model—experience also suggests that men and boys will accept a woman facilitator if she is informed and open minded. A third possibility is to work with pairs of co-ed facilitators. In addition to bringing two gender perspectives to the table, this arrangement offers an immediate model of equitable and respectful interactions between men and women.

What constitutes an appropriate age range for facilitators is yet another common question. Ultimately, the most important characteristic of a facilitator is to what degree he/she is non-judgemental and can model more gender-equitable attitudes and behaviours. However, it is important to keep in mind that in some settings peer educators may be more appropriate. For example, adolescent boys may not feel comfortable discussing certain topics, such as premarital sex, in the presence of an adult.

The duration of a group education programme can range from a single group discussion to ongoing weekly sessions. One study has shown that two to two-and-a-half-hour weekly group education sessions over a period of 10–16 weeks is the most effective 'dose' with regard to sustained attitude and behavioural change¹⁴ (Barker et al., 2007). Having multiple sessions and allowing a brief period of a few days or a week to elapse seems to be most effective because it allows participants time to reflect and to apply discussed themes to real-life experiences and then return to the group for further dialogue.

Bringing men and boys of different ages or backgrounds together can be a rich and rewarding educational opportunity. Nevertheless, it is also important that they have spaces in which to focus on concerns and experiences relevant to their own daily lives and relationships.

Young men between 15–19 years old, for example, often express concerns and doubts that differ from those between the ages of 20–24 years old. Younger men may

¹³ For more information about working with persons living with disabilities, visit the United Nations Voluntary Fund on Disability: <http://www.un.org/disabilities/default.asp?navid=8&pid=29> and UN Enable: <http://www.un.org/disabilities/index.asp>

¹⁴ However, although the evidence suggests that multiple sessions are more effective, some well-designed single sessions show evidence of self-reported change in attitudes and behaviour.

be more interested in discussing first sexual experiences, whereas older men may be more concerned with the daily challenges of parenthood or finding employment.

In general, group sessions should be limited to between 5 to 20 individuals in order to be most effective. A minimum number of individuals is necessary to ensure a sufficient level of interaction and discussion. A group that is too large may make it difficult for all participants to contribute.

Finally, there is the issue of whether group education should be carried out in mixed or single sex groups. In fact, each has its own advantages or disadvantages. Mixed groups allow men and women to hear each other's perspectives and to model better behaviours together. They can also serve to bridge the male-female

communication gap and offer an opportunity to jointly explore and understand gender relations and attitudes. However, if girls or women in a mixed group do not feel sufficiently safe or empowered, there is the risk that men or boys will dominate discussions and reinforce inequitable attitudes and power dynamics. Female-only groups can also allow women and girls to be more open and honest, particularly with respect to sexuality and emotions. The same holds true for male-only groups. In single-sex groups, however, men and boys do not have the opportunity to hear from women and girls or to comprehend their perspectives and the pressures they face. An interesting group education model, which includes a combination of single-sex and mixed-group sessions is presented in Case Study 2.

BOX 8

PARTNERSHIPS WITH WOMEN'S RIGHTS ORGANIZATIONS AND GROUPS

Efforts to engage men and boys in gender equality should always be aligned with ongoing efforts to promote women's and girls' rights. Some women's rights groups and organizations may initially express concerns regarding the effectiveness of working with men and boys and the potential for diversion of resources away from programming for women and girls. Some may also perceive work with men and boys as a seeking to promote "men's rights" or as being in opposition to women's rights groups. It is important that these concerns be addressed and a clear distinction be made between organizations that are working toward gender equality (and therefore in partnership with women's movements) and those that are not. Organizations that are engaging men and boys in gender equality need to be explicit that they share the same

vision and objectives as the women's rights organizations and movements. They also need to be careful to not present men and boys as victims or disadvantaged. Even as we recognize the costs to men of some rigid gender norms and masculinities, we must understand that men and boys (for the large part) have benefitted and still benefit from patriarchy and that they need to work in partnership with women in order to dismantle it. Working alongside women's rights groups and movements is necessary to lend credibility to the work with men and boys as well as ensure that the work accurately takes into account the realities and needs of women and girls.

BOX 9

MEN AND WOMEN AS PARTNERS IN ACHIEVING GENDER-EQUALITY

Although this toolkit is focused on strategies for working with men and boys, it is important to keep in mind that gender is relational and that both men and women must be involved in achieving gender equality. It is sometimes said, in fact, that mothers who raise sons and the wives and girlfriends who tolerate and obey men are responsible for male chauvinism. While gender norms are indeed constructed and reinforced by both women and men, many women are unable to change their social, economic and cultural contexts owing to powerlessness and economic dependency. Even so, through educational and campaign efforts, women (like men) can contribute to the promotion of gender equity by becoming more aware of oppressive beliefs and expectations within their own relationships and striving to overturn them.

In turn, programming with men and boys should engage them in promoting the rights and empowerment of girls and women. In particular, opportunities for men and boys to discuss gender inequality and health with girls and women can go a long way towards engaging them as allies for women's and girls' empowerment and health. At the same time, it is also important to retain spaces, which are solely for boys and men (as well as solely for girls and women) so that both groups are more comfortable discussing certain subjects. Either way, programming with men and boys should always be designed and evaluated in collaboration with existing efforts to promote the empowerment of girls and women.

CASE STUDY 1

PROGRAM H – WORKING WITH YOUNG MEN TO PROMOTE HEALTH AND GENDER EQUITY

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

The Program H (H for hombres and homens, the words for men in Spanish and Portuguese, respectively) educational curriculum is designed to promote more-equitable attitudes and behaviours among young men between the ages 15 to 24 years. Originally developed in Latin America and the Caribbean, the curriculum includes a manual featuring approximately 70 activities and a video. An evaluation undertaken in Rio de Janeiro, Brazil, in 2002–2004 confirms a positive impact with regards to gender attitudes, condom use and self-reported STI symptoms. (Horizons, 2004)

Manual activities include role-plays, brainstorming exercises, discussions, and individual reflections concerning how men are socialized, positive and negative aspects of this socialization, and the benefits of altering certain behaviours. Specific themes addressed include sexual and reproductive health (SRH); fatherhood and care-giving; violence prevention; mental and emotional health; and HIV prevention, treatment, care and support. Most of the themes and activities are proven to be universally relevant. Adaptations have been undertaken mainly in order to more accurately reflect local characteristics and settings.

The video, "Once upon a Boy", is an entertaining and thought-provoking no-words cartoon that tells the story of a boy and the challenges he faces growing up—including witnessing violence in his home, interactions with his peer group, his first unprotected sexual experience, an unplanned pregnancy and fatherhood. Because it is told without dialogue, the film can be shown anywhere. At the end of the screening facilitators can invite young men to interpret the thoughts and dialogue of the characters.

The Program H curriculum is used in more than 20 countries, and has been adapted for large-scale use in the Balkans region, India and Tanzania. Although primarily designed for young men, Program H materials are also used as training tools to sensitize and build the capacity of educators and health professionals to work with young men. One Program H partner, Salud y Género, uses the curriculum as part of a certification course on gender for health professionals and educators in Mexico. A number of educational activities from the Program H have been included in the tools section.

FOR MORE INFORMATION: WWW.PROMUNDO.ORG.BR



CASE STUDY 2

STEPPING STONES: WORKING WITH COMMUNITIES TO PROMOTE GENDER-EQUITY

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

Stepping Stones, a gender and sexuality curriculum, engages entire communities, young and adult men and women, through a series of workshops and community meetings. At the onset, community participants are divided into four peer groups based on age and sex—adult men, adult women, young men, and young women.

Over a three to four month period, peer groups participate in workshops and at fixed intervals convene with other peer groups. This provides young men and women with an opportunity to exchange ideas and debate issues related to gender, communication, relationships, sexuality, and HIV prevention among themselves.

At the conclusion of the workshops, facilitators arrange a community-wide meeting in which the peer groups present skits reflecting what they have learned and make their "requests for change." This community-wide

meeting is a fundamental component to the Stepping Stones package: It is the moment in which the community is mobilized to create strategies for the changes they would like to see in relation to SRH, gender roles, and overall well-being. After the community meeting, the groups continue to meet in order to sustain behavioural change and to support members.

Stepping Stones was originally developed in sub-Saharan Africa and has been widely adapted for use in Asia, Europe, and Latin America. A recent impact evaluation study in rural South Africa found that, among young men, the intervention is effective in reducing sexual risk-taking and perpetrating violence. Many of the participants (men and women) also spoke of improved communication with partners (Jewkes et al., 2008).

FOR MORE INFORMATION:
WWW.STEPPINGSTONESFEEDBACK.ORG



HEALTH AND SOCIAL SERVICES

Worldwide, women and girls generally have less access to health-related services and resources than do men and boys. Compared to women, however, men and boys often under-utilize health services—particularly those related to SRH and HIV prevention, treatment, care and support (Merzel, 2000; Travassos et al., 2002; Hudspeth et al., 2004). Reasons may range from cultural norms that laud self-reliance and inhibit health-seeking (and help seeking) behaviour to a lack of awareness and preparation on the part of health providers. (Armstrong, 2003; Hancock, 2004; UNFPA, 2003).

Engaging men and boys in health services therefore requires a dual approach: working with them to increase health-seeking behaviours and making health services more responsive. The focus below is on the latter: Emphasizing general strategies and taking steps to ensure that health services are more attractive and appropriate to men and boys. Educational, campaign and community mobilization efforts can, in turn, encourage men and boys to engage in healthy behaviours such as seeking support and services when needed.

It is absolutely critical to train service providers (either health professionals or other social services professionals) about how to work with men and boys—while at the same time recognizing that most are more familiar with working with women and girls. Additional training and sensitization are required in order to impart knowledge, boost confidence (re: engaging men and boys) and to foster attitude change among service providers (for example, men should be viewed as potential allies rather than obstacles in ensuring the health of female partners and families).

Along this lines, there is also the question of what role male staff can play in the provision of gender-friendly services. Often, there is the assumption that simply having male professionals on staff is sufficient for services to be considered "male-friendly." In other cases, it is taken for granted that male-friendly services are not possible without male staff. Research shows however, that the presence of male staff is more likely to attract men and boys and encourage both to utilize services. Some clients may hesitate to share intimate, especially sexual, information with a woman and are more likely to feel comfortable conversing with other males. However, the quality of service and whether the staff possesses the necessary knowledge, skills and sensitivity is what truly matters. Ultimately, men and boys prefer health and service professionals who will make them feel welcome and respected and who will be able to field their questions or refer them to someone who can.

The first impression of male-friendly services should be inviting and welcoming. Staff should greet men and boys warmly as they walk in. The physical appearance

of the office or center is important. Walls should preferably be adorned with posters and images of men and boys engaging in healthy and gender-equitable behaviours (e.g. offering a bottle to a child, speaking to a partner about an HIV test). In the waiting room, reading materials should appeal to males and include information outlining an array of services. Alternative hours (and sometimes alternative entrances) are also another way to assist women and men to feel more comfortable. All staff (including door attendants, guards, custodial staff and others who may interact with men and boys when they came in for services) should be trained to welcome the client and ensure that he feels at ease. (Survey with Health Providers is a tool designed to assess staff knowledge and comfort levels with regard to working with men and boys.)

Services that target men and boys should include direct health services (such as vasectomy, STI and HIV testing and treatment), individual and couple counselling (based in a clinic, hospital or social service centre), home visits and telephone counselling. These should encourage men to be more caring, equitable and involved with partners. They should also offer men an opportunity to develop communication and negotiation skills—from how to assist a partner to decide on a contraceptive method—to how to broach the delicate subject of HIV/STI testing. Such services can be integrated into existing services, or offered in separate male-only clinics—depending on community preferences, client needs, and available resources (UNFPA, 2000). Both strategies have proven successful. In some settings, men may be uncomfortable entering facilities historically associated with women. On the other hand, male-only clinics may only be viable in urban areas where there is sufficient client volume to sustain them. In sum, efforts to engage men and boys in health services should be implemented as an add-on to currently existing programmes and not as a replacement for other much needed services. (The tool "Checklist for Gender-friendly Services" highlights points to consider).

Ensuring that men and boys are aware of, and using services, can often require going outside the health post or clinic space to meet with them in the place where they will feel most comfortable. These can include schools, sports fields, community centres, bars and other places where men and boys tend to congregate. It is not necessary to offer a complete menu of services in these settings, but rather, to provide men and boys with basic information and materials about health and services, including condoms and Voluntary Counselling and Testing for HIV — otherwise known as VCT.

Outreach services utilize a variety of different approaches: Some train health care providers and community and social workers to understand and respond to the particular needs of men; others socially

market contraceptive supplies. Peer promoters can also be mobilized to reach out to men and boys in different settings and can provide valuable insights into the design and delivery of outreach activities and services. There are also a handful of service-based programmes, which can be undertaken in men's homes. These have been set up because some men are reluctant or do not have the time to seek out services.

Home visits and other types of community outreach are particularly critical when it comes to hard-to-reach, underserved or minority groups who might be suspicious of health and social services or do not have experience using them. In some settings, traditional healers can offer invaluable advice about how to design service-based efforts to reach men and boys.

CASE STUDY 3

YOUNG MEN'S CLINIC

(PROGRAMME TYPE: GENDER SENSITIVE)

Founded in 1987 by the Columbia University Mailman School of Public Health and New York-Presbyterian Hospital (NYPH), the Young Men's Clinic (YMC) provides health services to men between the ages of 14 to 35. Located in Washington Heights—a predominantly Latino, low-income neighborhood in New York City—the YMC meets three times a week in the same space as the Columbia/NYPH family planning clinic for women (which receives over 25,000 visits annually) during times when the family planning clinic is not in session. In 2008 alone, YMC received nearly 4,000 visits—a 30 per cent increase from two years before.

YMC offers physical exams for school, sports, and employment, episodic care for minor injury and illness, STI/HIV testing, group and individual health education, social work, and referral services to mental health, substance abuse, employment, education and dental services.

YMC staff are specially trained to address male sexual, reproductive, and other health needs. At intake and annual visits, for example, men are asked if they are victims of, or perpetrators of, intimate partner or family violence. Staff systematically track referrals and also provide capacity building for community-based organizations (CBOs) to prepare intake workers, teachers, social workers and other staff to assess men's healthcare needs and to advise them on how and where to refer

clients for sexual, reproductive, and other health services. The clinic creates a "male and minority-friendly" ambience by featuring frame photos of distinguished men of color (e.g. former Secretary of State Colin Powell; former U.S. Surgeon General David Satcher), paintings of men engaged in a variety of positive behaviors (e.g. holding a baby; attending school), and violence-prevention posters from the Men Can Stop Rape series. Teachable moments in the clinic waiting room are created by using PowerPoint presentations that help to engage men in group discussions concerning a variety of health topics. These include hypertension, stress and emotional health, STIs, and contraception.

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As part of a holistic approach to supporting young men, YMC uses "asset" maps of upper Manhattan neighborhoods to identify high quality, accessible, free or low-cost workforce development and alternative education programmes, legal services, community health centers, and dental clinics.

FOR MORE INFORMATION:
WWW.YOUNGMENSCLINIC.ORG

BOX 10**ARE MALE ONLY
SERVICES NECESSARY?**

Should services for men be integrated into existing services, or should men be served in separate male-only clinics or during special male-only hours? Experiences have shown that both strategies can be successful. In some countries, custom and tradition dictate the need for separate services for men; others have succeeded in expanding services within existing facilities. In terms of sustainability, it can be very costly to have space and staff dedicated exclusively to working with men and successful models have usually been based in urban areas, where there is a larger public of men. On the other hand, reserving a specific time for

attending men can be more cost-efficient and can help to attract them to the clinic. Also, services should recognize the diversity of men in their community and the diversity of services they will need to be ready to provide. Ultimately, decisions on which model works best should be formed by consultation with the community to determine its preferences, men's needs and the setting they are most likely to frequent, and, of course, available resources.

SOURCE: UNFPA 2003

CAMPAIGNS AND COMMUNITY MOBILIZATION

Campaign and community mobilization encompass a variety of interventions and approaches. These include: community meetings; training or sensitization sessions with traditional providers, community or religious leaders; street theatre and other cultural activities; marches, demonstrations, street and health fairs; and mass-media campaigns using radio, television, billboards or other media.

The most effective and promising campaigns and community mobilization strategies generally rely on up-beat messages that show what men and boys can do to alter their behaviour. The key to this is affirming that they can change, and showing them how by identifying characters in theatre, radio dramas, or print materials who are acting in positive ways (Barker et al., 2007).

Many of the most effective campaigns, for example, demonstrate to men and boys what they personally gain from changing their gender-related behaviour by showing men—both in relationships and out—as happy and fulfilled. Furthermore, although some campaigns and community mobilization efforts have successfully targeted a single behaviour or issue, such as showing men how to detect signs of maternal distress or encouraging them to use condoms or other family planning methods (see Case Study 2 and 3 in Sexual and Reproductive Health Chapter), evidence points to the need to include specific health issues within the context of an overall gender-equitable male identity or lifestyle. The most effective interventions rely often on such social marketing methods (Barker et al., 2007).

Many effective campaigns and community mobilization efforts identify strong male role models: Groups or individuals who can influence the behaviours of other men—including coaches, fathers and religious

leaders. These influential men could be celebrities or ordinary individuals from the communities in which the campaign is to take place. The most important thing is that they model gender equitable behaviour and command respect from the men and boys they are seeking to influence.

Sports, in particular, can serve as a powerful and far-reaching medium from which to launch campaigns and mobilize communities. There are a number of ways in which sports can be utilized to engage men and boys with campaign activities and messages related to gender equity and health promotion— from using sports events to encourage men and boys to participate in educational workshops or by integrating health promotion information and related messages about gender and relationships into sports activities.

Examples of strategies include: This latter strategy can featuring influential sports role models speaking out during half-time about healthy, positive and equitable ways of being men; distributing informational materials with key messages about gender-equity and health at sporting events, and; recruiting coaches and/or sports team members to serve as peer educators for other team members and/or the community. However, many sports emphasize aggressiveness or competitive masculinity and it is important that campaigns or other communication strategies do not reinforce negative masculine stereotypes, but rather, emphasize cooperation and respect (UNFPA, 2000).

The tools "Designing a Campaign Step by Step" and "Campaign Do's and Don'ts" provide some guidelines on how to design gender-transformative campaigns.

BOX 11**INVOLVING COMMUNITY STAKEHOLDERS IN THE DESIGN AND/OR EVALUATION OF CAMPAIGNS AND OUTREACH EFFORTS**

- Meet with community leaders and stakeholders (making sure to reach out to as many as possible) as soon as you begin the initial project or campaign/outreach efforts;
- Present how engaging men and boys in health promotion efforts will benefit the community as a whole;
- Involve them in a baseline analysis of the needs and realities of the target audience (men and boys);
- Include them on advisory committees and/or ask them to participate in reviewing campaign messages, educational curricula and other materials;
- Keep them regularly informed of activities;
- Invite them to ceremonial occasions, possibly as guest speakers in workshops;
- Encourage them to be advocates for the cause and to speak to others about its value;
- Provide concrete suggestions of how they can help support positive attitudes and behaviours among men and boys.

BOX 12**SOCIAL MARKETING**

Traditional public health campaigns tend to focus solely on “informing” people of unhealthy behaviours and their consequences and often affect a dictatorial or moralizing tone. Experience has shown, however, that these types of campaigns rarely engage audiences or inspire behavioural change (Hornick, 2002; Randolph and Viswanath, 2004).

Because of this, public health campaigns are increasingly deploying methods used in commercial marketing to “sell” healthy behaviours and lifestyles. “Social marketing” encourages specific behaviours and lifestyles by making them more attractive to the target audience by emphasizing benefits and advantages.

To develop a social marketing campaign, it is important to first understand the underlying socio-cultural norms that

contribute to particular behaviours¹⁵. Much behaviour is influenced by perceptions of what appears to be “normal” or “typical”; that is—what many believe their peers think or do.

However, many individuals, including youth, often misperceive what they consider to be the typical behaviour or attitudes of their peers. For example, a young man may believe that a majority of his peers engage in certain risky behaviours, such as excessive drinking, when in most settings the majority in fact do not (Perkins et al., 2005).

Because the media or social norms often fuel misperceptions of what is considered to be a “real” man, young men may be more likely to engage in destructive behaviours. It is critical that campaigns address these and promote more positive norms of what it means to be a man.

¹⁵ A specific form of social marketing, which is known as social norms marketing, is based on applying social marketing techniques to social norms theory. The central concept of social norms theory is that behaviour is influenced by the perception of what is “normal” or “typical”. To this end, the primary premise of social norms marketing lies in informing individuals that the majority of their peers are acting in a positive or healthy way. This can in turn create an environment in which people actively strive to emulate what they believe is typical of their peers. This approach has been proven effective with regards to preventing tobacco use and drinking and driving—among other issues. For more information visit the Most of Us website at www.mostofus.org

CASE STUDY 4

THE STRENGTH CAMPAIGN

(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

The Men Can Stop Rape (MCSR), an international organization that mobilizes men to stop violence against women, launched the Strength Campaign. The aim is to employ different media and community outreach and mobilization strategies to engage young men in more positive and equitable behaviours, like being allies in the prevention of date rape.

The Campaign is organized around the slogan "My Strength Is Not for Hurting" and its goal is to refocus the traditional perception of male strength as respect and communication, as opposed to force and domination. In addition to the media initiative, the Strength Campaign also includes an educational component called the Men of Strength (MOST) Club. Young men in MOST Clubs participate in a series of sessions intended to raise their awareness of the importance of male involvement in rape prevention and mobilize them as active allies in the prevention of violence against women and girls.

Originally launched in Washington D.C., the Strength Campaign also links up with other school-based initiatives. School administrators, teachers and other staff participate in awareness-building workshops and are invited to serve as members of the campaign's advisory committee and participate in the design and

management of in-school activities. Campaign efforts are not isolated from other school-based efforts, but rather "owned" and implemented locally.

One of the most salient concerns which emerged from the initial research and testing was that young men feared that if they spoke out about violence against women, or changed their ways, they would be alone. For this reason, the campaign images show young men with partners and/or with other young men in order to emphasize the benefits and solidarity related to taking a stand against male violence and speaking openly about respecting women.

The campaign focus on promoting positive gender norms allows for it to also be adapted to engage men in other social and health contexts. Since its launch, more than two hundred local, regional, and national organizations have used the campaign posters and materials to establish a nationwide presence. More recently, Men Can Stop Rape started a new campaign targeting all branches of the United States military. "My Strength is for Defending" seeks to address sexual harassment and sexual assault in the military. The Strength Campaign materials have also been used in other countries.

FOR MORE INFORMATION: WWW.MENCANSTOPRAPE.ORG

CASE STUDY 5

SEXTO SENTIDO, NICARAGUA

(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

Somos Diferentes, Somos Iguales (We're Different, We're Equal), coordinated by the Nicaraguan NGO Puntos de Encuentro, is a national multi-media campaign designed to empower youth, promote gender-equity and reduce violence and STI/HIV risk. The centrepiece is a nationally broadcasted TV soap opera, "Sexto Sentido" (Sixth Sense), which targets youth and addresses sensitive and complex issues such as sexuality, HIV and AIDS, reproductive rights, and domestic violence by dramatizing them within realistic and entertaining storylines.

Soap opera messages are reinforced through interactive and community-based activities, which serve as platforms for public discourse and debate. These activities include a daily youth call-in radio programme and cast tours to local high schools around the region which provide youth with an opportunity to voice their opinions, share experiences, challenge biases, negotiate different viewpoints and make decisions about how and where to create change in their lives (Solárzano et al., 2006). Puntos de Encuentro also partners with a network

of youth- and women- friendly health and social service providers around the country who receive referrals to assist with problems, concerns, or further questions that arise during campaign activities.

An evaluation study carried out in 2003-2005 confirmed that there is a cumulative message dose effect: the more messages young people are exposed to (e.g. via the multiple elements), and the longer the period of exposure, the more likely they are to have a "positive" attitude toward the issue. This in turn, motivates behavioural change, including those relating to gender attitudes and HIV prevention behaviours (Solárzano et al., 2006).

The last episode of Sexto Sentido was broadcast in June 2005. The series is currently being repeated in its entirety (80 episodes) on local TV stations around the country and is broadcast on major TV channels in Costa Rica, Guatemala, Honduras and Mexico.

FOR MORE INFORMATION: WWW.PUNTOS.ORG.NI

TOOLS

- Education: Understanding the Gender Continuum
- Education: Learning About Gender
- Education: Act like a man, Act like a woman
- Education: Persons and Things
- Education: Tips for Facilitators
- Services: Checklist for Gender-friendly Services
- Campaigns: Creating a Campaign - Step by Step
- Campaigns: Community Campaigns
- Do's and Don'ts
- Campaigns: Door to Door Visits

Sexual And Reproductive Health



The international commitment to engage men in sexual and reproductive health (SRH) and its importance in the context of promoting gender equality was affirmed in the International Conference on Population and Development (ICPD) Programme of Action and in the Beijing Platform of Action in 1994 and 1995, respectively (see Box 1). The commitment to include men in SRH formed part of a paradigm shift from a demographic to a more holistic and rights-based understanding of SRH (UNFPA, 2000; Greene et al., 2006).

This shift entailed rooting programmes and policies in human rights and prioritizing individuals and their needs over demographic goals. In many ways, the HIV epidemic was also responsible for increased attention to how gender and other socio-cultural norms influence men's and women's SRH (UNFPA, 2003).

It is now widely acknowledged that engaging men in SRH programmes and policies is necessary both for their own health and well-being, as well as that of women and children. Furthermore, as discussed in the introduction, engaging men and boys in SRH requires addressing the rigid traditional gender norms and power dynamics that underlie their SRH-related attitudes and behaviours and interactions with partners.

Worldwide, boys and men are raised to believe that to be "real" men they need to be strong and in control—particularly with respect to their intimate and sexual relationships. Sexual experience, frequently associated with initiation into manhood, may be viewed by men and boys as a sign of sexual competence or accomplishment, rather than acts of intimacy (Marsiglio, 1988; Nzioka, 2001).

Indeed, although men and women construct their identity through their sexuality and sexual experiences, societal norms regarding both tend to differ. Having multiple sexual partners, for example, may be seen as proof of manhood. Contraception, in turn, may be considered a "woman's concern".

Research undertaken worldwide finds that between 28 per cent and 59 per cent of unmarried sexually experienced young men have had two or more sexual partners during the last year and, of these, 39 to 68 per cent did not use a condom the last time they engaged in intercourse (Guttmacher, 2003). Because it is often men who wield most of the decision-making power¹⁶, their knowledge and attitude concerning family planning and prevention of STI/HIV can have serious implications for both themselves and their partners.

Norms that promote the idea of men as being self-reliant and invulnerable may make them hesitant or unwilling to seek help for their SRH needs. Research has found that men and boys in many settings (North America, parts of Europe, Latin America and parts of sub-Saharan Africa) may delay seeking help longer than women and girls and often will only do so after they have suffered significant personal consequences (Kutcher et al., 1996; Addis and Mahalik, 2003; Hudspeth et al., 2004).

Health professionals may in turn believe that men are disinterested in information and services and focus their efforts on women (WHO, 2000). These norms and barriers to men's help-seeking behaviour may also discourage men from being involved in their partners' health.

¹⁶ This "control" over reproductive decision-making varies across contexts, and seems to be weakening, particularly among young generations and in contexts where women's levels of education and literacy are increasing (UNFPA 2000).

BOX 1**INVOLVING MEN IN SEXUAL AND REPRODUCTIVE HEALTH:
AN INTERNATIONAL COMMITMENT**

The 1994 International Conference on Population and Development (ICPD) in Cairo called for a rights-based approach to SRH including a recognition of the active role that men can play with regard to childrearing as well maternal health. The ICPD marked the beginning of an international consensus on how gender norms harm both men's and women's health and impede development, and the need for more systematic attempts to address gender norms in programming and policies.

The "family planning approach," which predominated before ICPD, mainly targeted women and prioritized contraceptive use and fertility as indicators of progress. A prominent aspect of this shift to a broader and more rights-based health agenda has been the evolving dialogue about engaging men in health programming and policies. Below are some excerpts from the Programme of Action which specifically address the need to engage men in the promotion of SRH:

"The objective is to promote gender equality in all spheres of life, including family and community life, and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. ICPD Programme of Action (Paragraph 4.25)."

"Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be

included in education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children. ICPD Programme of Action (Paragraph 4.27)."

"In terms of young men and sexual and reproductive health, the ICPD recognizes that the 'health needs of adolescents as a group have been largely ignored' and that the 'responsible sexual behaviour, sensitivity, and equity in gender relations instilled during the formative years (will) enhance and promote respectful and harmonious partnerships between men and women.' ICPD Programme of Action (Paragraph 7.41 and 7.34)."

The 1995 Fourth Conference on Women in Beijing, China emphasized the need to achieve gender equity in order to improve reproductive health. Below are some excerpts from conference documents which specifically address the need to engage men in the promotion of sexual and reproductive health:

"Encourage men to share equally in child care and household work and to provide their share of financial support for their families, even if they do not live with them; 107(c)."

"...facilitate promotion of programmes to educate and enable men to assume their responsibilities to prevent HIV/AIDS and other sexually transmitted diseases; 108 (e)."

"Design specific programmes for men of all ages and male adolescents, recognizing the parental roles referred to in paragraph 107 (e) above, aimed at providing complete and accurate information on safe and responsible sexual and reproductive behaviour...108(l)"

A number of factors—socio-economic status, age, religion, race, and ethnicity for example—interact with gender to shape male SRH needs and behaviours. In terms of socio-economic status, poverty and poor employment prospects can undermine the ability of men to fulfil their traditional role as providers—some research has found that men may compensate for this perceived loss of "manhood" by having more sexual partners, or by using violence, including sexual violence (see, for example, Silberschmidt, 2001).

Unemployment may also force men (especially young men) to leave their homes and families in search of work. This separation may prompt some to engage in high-risk sexual relationships (Guttmacher 2003; Yang et al., n.d.). Low socio-economic status may also mean that men have limited access to information and services.

In contrast, there is evidence that education and economic security can have a positive impact on SRH behaviours—for example, lengthier schooling and increased prospects for a better standard of living often result in the postponement of marriage and childbearing to later ages for both men and women. Improved schooling and employment levels among women, in particular, can lead to positive changes not only in the perceptions of gender roles, but also in the actual relationships and dynamics between men and women.

Conversely, other studies suggest that, in some situations, the demands of poverty can also lead to greater flexibility with respect to gender roles: An unemployed low-income man, for example, may take on domestic tasks, including child care, so that his partner can work (Barker, 2000). Youth who migrate to cities for work and live away from

rigid family and community controls may be exposed to alternative and more equitable models of male-female relationships and behaviours.

These contrasting examples underscore the fact that there is no formulaic way in which class or other factors influence gender or SRH—rather, it is a confluence of many factors that vary from individual to individual.

In discussing the linkages between gender and SRH, it is also important to think about how men's SRH needs, vulnerabilities and behaviours change over the life cycle. Although SRH is most often associated with adults and adolescents, the norms of male power and risk-taking that lead to SRH vulnerabilities are taught through socialization that begins in infancy and continues throughout childhood. It is therefore necessary that SRH programmes and policies also consider how to engage both parents and children with messages about gender-equity and the importance of sharing life roles and responsibilities.

During adolescence and youth¹⁷, men's SRH needs and vulnerabilities are influenced by social expectations surrounding their transition from childhood to young adulthood, including sexual debut, marriage, education and work. In Sub-Saharan Africa, Latin America and the Caribbean, and the United States, about 6 to 10 years elapse between the age at which men first have sex and the age at which they first marry. This is a period during

which many men will be unmarried but sexually active—often with more than one partner.

Most men between the ages of 20–24 report having had sex by the age of 20. Comparatively few men in this age range have children, fewer even among men aged 15–19. Many are in school or acquiring work experience or are searching for work, unemployed or working in low-paying jobs. Though young men may have sex with more partners than older men, it is generally more sporadic. In one study undertaken in 17 countries, only one-half of sexually active men between the ages of 15–24 had reported having sex during the last three months (Guttmacher, 2003).

Research has found that peers significantly influence adolescent and young men's behaviours and attitudes particularly with regard to relationships and sex. Surveys have also revealed that adolescent and young men remain largely ignorant of their own or their partner's sexuality, do not discuss health and HIV prevention with partners and have misconceptions about and often limited access to condoms and other contraceptive and prophylactic methods (UNFPA, 2003).

Most men between 25 and 39 years of age have already married at least once and are generally employed. In most countries, employment is seen as a precursor to marriage, without which a man is not considered marriageable. Following marriage, most men will

BOX 3

WHAT IS SEXUAL AND REPRODUCTIVE HEALTH?

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination and violence.

Reproductive health is a state of physical, emotional, mental and social well-being in relation to the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

SOURCE: WHO TECHNICAL CONSULTATION ON SEXUAL HEALTH, JANUARY 2002



¹⁷ "Adolescents" are generally defined as those aged 10–19 and "youth" as those aged 15–24.

become fathers. A study across 10 countries found that 80–90 per cent of men between the ages of 30–39 have married and the vast majority of these have fathered a child (Guttmacher, 2003). Only when they are in their early 30s (in the United States and in Latin America and the Caribbean), and in their mid-50s (in Sub-Saharan Africa), do half of the men surveyed decide that they have had all the children they want. At this point, although many men may remain capable of fathering children, a larger proportion do not want any more children and need the skills and methods to avoid further pregnancies (see Box 6 – Men and Vasectomies, for example).

Almost all men in their 40s or 50s are married while

some are on their second or third marriages. In developing countries only about 1–8 per cent of men in this age range have never had a child and up to 11–18 per cent in industrialized countries (Guttmacher, 2003).

The majority of married men also report that they have had as many children as they want, except those living in Sub-Saharan Africa. As men age, they (and their health care providers) may assume that they no longer have a need for preventive measures and SRH services. However, many older men (and women) may be at risk for STIs/HIV and not realize it. Medical services to treat infertility and impotence or that offer vasectomy and cancer screening also become increasingly important as men age.

BOX 3

WAYS FOR MEN AND BOYS TO BECOME ENGAGED IN SEXUAL AND REPRODUCTIVE HEALTH¹⁸

- Learn about their bodies and changing SRH needs
- Learn how to talk about sex, sexuality and reproduction in gender equitable and open ways; admit when they have doubts and ask questions about them; get the information they need from good sources
- Seek care/getting regular health checkups, including for STIs
- Share responsibility for family planning, contraception and/or prevention of STIs
- Use contraception consistently (when it has been agreed upon by both partners) and support partner's contraceptive use, including male and/or female condoms
- Plan their families and support their partner's use of Maternal and Child Health services as necessary
- Only engage in sexual relations that are equitably negotiated, mutually desired and non-coercive; focused on giving as well as receiving pleasure
- Reject, avoid and try to prevent all forms of GBV including domestic violence, sexual violence, and harmful practices such as child marriage, bride kidnappings, dowry related violence, honour killings, female genital mutilation/cutting and prenatal sex selection
- Understand their partners' needs regarding SRH and sexual pleasure
- Support partners' decisions regarding their own body
- Support and promote sexual education in their communities

WHAT ARE MEN AND BOY'S SEXUAL AND REPRODUCTIVE HEALTH NEEDS?

Worldwide, men report needing accurate, clear, and non-judgmental information, including about the physiology of reproduction, healthy and mutually enjoyable sexual relationships, and skills-building on how to communicate with partners about SRH, protection against STIs, contraception, and condom use. It is important to remember, however, that information needs change over the course of a man's life. For example, before puberty boys need to learn about the physical and hormonal changes that are about to transform their bodies and their sexual and emotional

feelings. Young and adult men also need basic SRH information, as well as a more detailed understanding of their bodies and how to give and receive pleasure. For example, many young and adult men (in some settings) may worry about the quantity and quality of their semen, of which they believe they have a limited supply, and some worry about the size and shape of their sexual organs and about their ability to perform sexually. From an early age, boys and younger men also need the opportunity to build skills to help them resist peer pressure and communicate with their partners

¹⁸ This list is adapted from the programming experiences of EngenderHealth and Promundo and is not meant to be exhaustive.

about personal and sexual matters. Older men also need to learn about the changes their bodies will undergo and learn how to accommodate these so as to continue to enjoy fulfilling sexual relations.

Before becoming sexually active, young and adult men need information about the difference between male and female sexual response cycles, how to communicate mutually about sexual needs and preferences, how to effectively use condoms and other methods to prevent STIs and unplanned pregnancies. A common belief among many young men is that they should "know it all" about sexuality and sex, when in fact they are frequently uninformed or misinformed on these matters.

Data from around the world indicates that only 40 per cent of young men have accurate knowledge about HIV and the proportion of men aged 15–54 who know that condoms can prevent HIV varies widely in developing countries—from 9 per cent in Bangladesh to 82 per cent in Brazil (UNAIDS, 2008; Guttmacher, 2003). It is also important, for example, that men are made aware that HIV is more easily transmitted sexually from men to women than from women to men and that their own high-risk behaviours have implications for the health of their partners and families (Link – See HIV section for more information about how to engage men and boys in HIV prevention).

In addition to information, men also need to learn about how to communicate with their partners about STI prevention and contraception, to use methods correctly and consistently, and to deal with unplanned pregnancies. Men also need access to family planning methods, counselling, testing and treatment for STI/HIV and the support and skills related to voluntary partner disclosure and notification. In some settings, men who become infected with STIs (including HIV) may try to treat themselves, seek care from pharmacists, traditional healers, or others who may not have formal training in the treatment of STIs.¹⁹ Research has found that men might prefer consulting with informal practitioners because they are more affordable and/or because they believe that they are more respectful and less judgmental than private doctors or health care workers working out of family planning clinics (Guttmacher, 2003). Later in this section, strategies for ensuring that health professionals, clinics and other service spaces are more welcoming to men, are discussed.

As previously mentioned, many men may view reproduction and family planning as a female responsibility. This is in part owing to norms that emphasize men's sexuality and undervalue responsibility with regards to reproduction and in part to the fact that most contraceptive methods and family planning

programmes and services are female-centred. Research has shown, however, that many men have an unmet need for family planning (UNFPA, 2000).

It is estimated that between 20–46 per cent of men aged 25–54 in Sub-Saharan Africa and 15–30 per cent of those in Latin America and the Caribbean do not want a child soon or at all but are nevertheless not protected against unplanned pregnancy (Guttmacher, 2003). Furthermore, a large proportion of married men aged 25–39, particularly in sub-Saharan Africa, say that they have not discussed family planning with their partners—highlighting the extent to which lack of communication between partners leads to lost opportunities to meet family planning preferences and needs (UN Millennium Project, 2006).

At the same time, it is important that family planning efforts address the dynamics of a couple's reproductive decision-making (UNFPA, 2000). Men may have their own perspectives and preferences regarding fatherhood and how many children they want and they need to be able to balance these with their partners' preferences and the health benefits of planning pregnancies.

Family planning efforts therefore need to include support and skills building aimed at enhancing communication and negotiation between couples as well as information about, and access to, methods. It is important that couples discuss the number and spacing of children and decide together which contraceptive method (or combination of methods) best meets their needs (see, for example, Box 7 Promoting Men's Use of Condoms and Box 6 Men and Vasectomies).

As men grow older, they need to know about vasectomy, the diagnosis and treatment of infertility, sexual function and dysfunction or cancers of the reproductive system. Throughout the life cycle of men, however, the emphasis needs to be on continued safe sexual practices, including correct and consistent condom use, and an understanding of the potential vulnerabilities that exist in all stages of life, whether a man is married or single.

Finally, it is important to remember that many men are already fulfilling (and in some cases expanding) their roles and responsibilities to engage in loving, pleasurable and life-enhancing sexual relations. They are also avoiding the potentially negative consequences of sexual activity—primarily unintended pregnancies and STIs—despite receiving little guidance or support from peers, services or their communities. These men, too, can benefit from information and services that will help them adapt to their changing needs and circumstances and enhance both their own sexual fulfilment and that of their partners.

¹⁹ In the section on HIV, we discuss in more detail the specific considerations and strategies for engaging men in prevention, care and treatment.

PROGRAMMING FOR ENGAGING MEN AND BOYS IN SEXUAL AND REPRODUCTIVE HEALTH

Historically, most SRH programmes and policies have focused on clinical or service settings. As discussed earlier, however, education and community-level efforts are also necessary to change the behaviour and social norms that stand in the way of promoting SRH.

SRH providers need to be more responsive and spaces more attractive. It is also critical that providers work with men to increase health-seeking behaviours and mobilize peer counsellors and utilize community spaces to promote positive sexual and reproductive behaviours while, at the same time, questioning rigid norms that lead to SRH vulnerability.

GROUP EDUCATION

Most existing SRH education efforts have centred on condom use, STIs, and HIV with relatively little information paid to men, family planning, and sexual health more broadly. Specific topics which need to be addressed include: male and female anatomy, sexual pleasure, sexual dysfunction, STIs, contraceptive methods, consistent and correct condom usage, shared decision-making and communication among sexual partners. Providers should also encourage discussions around diversity of sexual identities and practices.

Group education should offer a space where men can acquire accurate information. Participants should learn how to care for their own SRH as well as that of their partners. They should learn how to better communicate and share decision-making with women concerning a range of issues—such as if and when intercourse occurs, what each partner likes and doesn't like, how many children to have and when and what contraceptive method to use.

In many settings, SRH education can be a contentious and taboo topic—particularly when it involves boys and young men. Parents, family, teachers, religious leaders and policymakers may be uncomfortable talking about it or even supporting the notion that youth have access to SRH-related information or services. These "gatekeepers" may also be unaware of the links between gender and SRH vulnerability and doubt the need for, or utility of, educating young men and boys.

Ongoing advocacy is needed to make sure that men and boys enjoy an enabling and supportive environment. From the very outset, programmers should invite gatekeepers and other partners to participate in, and contribute to, programmes. Whenever possible, programmers should integrate education efforts into health services and social communication campaigns, as well as in school and vocational training programmes.

Schools are a good place to reach large numbers of boys and young men with information about SRH. In many settings, schools already offer health and family life curricula, alongside general information about how to prevent STIs. However, these rarely include critical examinations of gender and sexuality and how these increase the likelihood of acquiring STIs (including HIV), increase the risks of unplanned pregnancy and other SRH-related problems.

To effectively establish, review and adapt curricula requires both advocacy and technical effort. Administrators and educators need to be sensitized to the necessity of including a gender perspective into all programming and to impress upon students the need to take a stand against violence. Programmers should offer students, families, and other stakeholders an opportunity to review material. Images and messages should be vetted to make sure that they do not contain harmful stereotypes while specific activities with respect to gender and masculinity should be added. Moreover, it is important to provide students with an opportunity to ask questions about the SRH issues that really concern them.

In addition to integrating a gender perspective into programming, staff should offer sensitization, comprehensive training and support to school staff, especially for those teachers or other educators who directly implement gender, sexuality and SRH curricula. Many teachers may be unaware of how critical it is to work with boys or young men, or about how to undertake gender and sexuality activities that are appropriate and sensitive. Such training allows teachers an opportunity to examine their own attitudes about gender and sexuality.

Furthermore, many teachers and educators may not possess a great deal of experience with non-didactic

and highly participatory teaching methodologies. Most will need to develop the relevant facilitation skills. Local organizations that specialize in health education using participatory methods can help teachers to learn these techniques. It is essential that peers and students trust sex education teachers. This will minimize the risk of abusive, violent or disrespectful behaviour both on the part of students and of the teachers themselves.

Implementing a gender perspective into curricula should not be an isolated effort. Broader efforts to promote a more gender-equitable school environment should reinforce programming. Schools can be violent places characterized by bullying, abuse, sexual harassment and other violence between students as well as by teachers. School administrators need to establish reporting and sexual harassment policies, and offer instruction to educators about how to be more gender equitable in the classroom, including how to encourage girls and boys to participate in activities traditionally dominated by one sex or the other. School-based efforts should also promote links with local SRH services through referrals, onsite services or other strategies.

Finally, many of the same elements offered in school-based education apply to education efforts with out-of-school youth and adults—particularly the need for participatory activities and well-trained facilitators. Other elements, however, need to be adapted according to a specific context or target group. For example, out-of-school youth and/or working youth and adults will need more flexibility with regards to scheduling sessions. Whenever possible, programmers should try to link out-of-school youth to ongoing school-based SRH

BOX 4

REVIEWING SEXUAL HEALTH CURRICULA

When creating SRH curricula programmers need to consider if images and messages:

- Polarize women and men, and if so: Are men presented as the bad guys and women as passive?
- Address emotional aspects of male sexuality, or do they present male sexuality as primarily physical?
- Present a narrow definition of what it means to be a man?
- Prescribe roles for men that are restrictive or constraining?
- Represent male sexual desire as more potent, more urgent than female sexual desire?

SOURCE: SEX EDUCATION FORUM FACT SHEET 11

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education efforts in order to try to reintegrate them into the school system.

Services that are welcoming and responsive are more likely to attract male clients. Unfortunately, despite evidence that shows that male involvement results in better health outcomes, health services still tend to exclude men—particularly when it comes to respecting their personal needs and acknowledging that they play a valuable role in childbearing, contraception, and STI/HIV prevention (UNFPA, 2000 ; Kunene, et al., 2004).

Where youth sexuality and reproductive health is a taboo topic, laws and policies may prevent young men and women from accessing SRH services. Even when these services are made available, they often require the presence or authorization of a parent or guardian, thus prohibiting or limiting opportunities for youth to access confidential services.

Men may also resist using services too closely associated with women because they feel staff might be insensitive to their needs. Many men actually prefer to seek assistance from their peers and from local pharmacies rather than through formal health services. They are also more likely to only seek health services in an emergency or when they need to obtain condoms (Barker, 2000; Pearson, 2003). Research conducted by Promundo in Rio de Janeiro, Brazil for example, showed that young men living in low-income neighbourhoods are more likely to use "home remedies" or medicines recommended by colleagues and peers to treat suspected STI symptoms, than to seek out formal health services (Promundo, 2006).

In order to attract men, services should be accessible, welcoming, sensitive to male needs and consonant with existing community values. Programme staff should seek men out where they tend to congregate; and projects must be carefully tailored to meet the special needs of young, low-income, minority, gay and bisexual men. Programmers also need to reach men living with disabilities, and other groups historically marginalized from social and health services.

The good news is that research has shown that accommodating men can be undertaken with low-cost, simple changes. These include changing the clinic layout, shifting hours of service, and either retraining female health workers or hiring more male staff (See Tool "Checklist for Gender Friendly Health Services" in the Introduction).

Services should also be flexible and respond to changing SRH needs. For example, a young man in an unstable relationship will have different needs than a middle-aged married man with two children or an older man



dealing with prostate cancer. In addition to making men and boys feel welcome, it is also necessary to inculcate men and boys with more positive views about gender equity and to provide services and activities that help to facilitate more open and equitable communication with partners. Service providers also need to be more open and non-judgemental when it comes to listening to the concerns and needs of men who express sexual behaviour and identities outside of the norm.

An inventory of SRH services geared towards men and boys will include the following categories:

1. Screening:

This involves taking a full medical history—including SRH history that includes STI and HIV screening—substance use and mental health needs; anger management and violence risk screening (See Tool – “Taking a Comprehensive Sexual History”).

2. Information and Counselling:

This involves listening to questions and concerns in a non-judgmental way and providing information and counselling on various topics related to SRH. This includes issues relating to male and female anatomy, the sexual response cycle, genital health and hygiene, basic fertility, sexual pleasure and dysfunction, contraceptive methods, STI and HIV prevention, pre-natal and postpartum care and inter-personal communication skills, condom use and VCT with partners²⁰.

3. Clinical Diagnosis and Treatment:

This is the provision of services and/or referrals for the diagnosis and treatment of problems detected during the screening procedure. This includes STI and/or HIV diagnosis (including anal examination), treatment for impotence, fertility evaluations and vasectomy counselling (Source: UNFPA, 2000).

It is unlikely that any single clinic or agency can directly provide all of these services. Nevertheless it is critical that programmers understand the range of services required and to be prepared to refer clients to services unavailable on-site. Likewise, including SRH care within a broader menu of services is another way to attract men and boys. Offering other types of services can help to reduce the embarrassment or stigma associated with a SRH health or HIV prevention clinic.

For example, in New York City the Young Men's Clinic (see Case Study 3 in the Introduction), primarily provides SRH health-related services, yet, it also provides a range of other services, including general physical examinations, counselling and the treatment of sports injuries and acne. These “other” services allow men to broach more delicate and intimate questions about sexuality, relationships, reproductive health, mental health, and HIV prevention without fear of stigma (Armstrong, 2003).

²⁰ For more information on HIV testing and counselling see the UNAIDS guidelines for service providers at http://www.who.int/hiv/pub/guidelines/9789241595568_en.pdf

BOX 5**EXAMPLES OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR MEN²¹**

- An assessment based on SRH history
- Testing, education, counselling and treatment for STIs/HIV
- Listening to and answering questions about sexual function, pleasure and sexual orientation without judgment
- Screening for testicular and penile cancer
- Information about alcohol or drug dependence or abuse
- Screening for depression and referral for mental health support
- Screening for GBV
- Counselling on the prevention of GBV
- Counselling for and access to family planning methods, including how to make condom use sexy and safe
- Infertility counselling
- Information on pre-natal and post-partum care and support
- Care-giving and parenting skills
- Communication and negotiation skills-building
- Sexual dysfunction and impotence services and counselling
- Vasectomies
- Information on sexual pleasure (for the clients and their partners)
- Positive images of gentle, gender-equitable men
- Access to support groups for new fathers
- Access to support groups for men dealing with violence

BOX 6**MEN AND VASECTOMIES**

Because vasectomy services are not widely available many men are unaware of their existence and of how simple the procedure is. Indeed, the procedure is extremely rare in all but a few industrialized countries and in China (Guttmacher, 2003).

Common misperceptions about the effect of vasectomy on sexual function may also discourage men from considering the procedure despite the fact that it offers many advantages. Chief among these is that it is simpler and more

cost-effective than female sterilization, offers men a convenient, effective form of contraception that they control and most importantly, allows them to share responsibility for family planning. Nevertheless, despite these advantages, vasectomy continues to be underutilized as a family planning method.

SOURCE: LANDE AND KOLS, 2008

As discussed earlier, engaging men and boys at the service delivery level means that staff need to be prepared. Many providers have little or no experience working with men and/or issues related to SRH. Moreover, traditional medical training often emphasizes technical knowledge but not necessarily an understanding of issues such as power relations between and among men and women and the various, interpersonal and societal factors that influence SRH decision-making and behaviours.

A simple needs assessment (See Tools “Needs assessment questionnaire for Health Facilities Staff”)

can help to identify the degree to which staff are committed and prepared to work with men. All should receive the requisite training as to why it is necessary to work with men as well as an opportunity to deconstruct their own gender beliefs—including assumptions about heterosexuality being the only (acceptable) norm, and how these can affect their professional interactions with men and boys.

Staff should also try to move beyond stereotypes that frame male sexuality as irresponsible, uncontrollable or predatory. These limit the extent to which health professionals are able to reflect critically on, and address

²¹ This list is adapted from programming experiences of EngenderHealth and Promundo and is not meant to be exhaustive.

the specific SRH needs of men. It is also important to provide training and support culturally appropriate care because there may be particular sensitivities related to sexuality and reproductive health among men from different backgrounds.

Furthermore, staff should also be trained to actively encourage or “recruit” men to use services. Many

men, for example, will often accompany their partners to clinics but may be too shy themselves to actually approach the staff or to ask questions. Peer educators who are available to engage men in the waiting room and the presence of targeted materials can help overcome their hesitation. As discussed below, campaigns and other community-based activities can also play a key role in attracting men to services.

BOX 7

PROMOTING THE USE OF CONDOMS AMONG MEN

When used consistently and correctly male condoms are effective against STIs and unplanned pregnancies. Because many men access health services specifically to obtain condoms, it is critical that health providers take advantage of this opportunity to provide accurate information and education with respect to condom use, as well as to provide materials and information about SRH and other available services.

Many sexually active men—particularly young men—are concerned with unplanned pregnancy. Health professionals and educators should promote condom use in the context of dual protection—that is, emphasizing that condoms are suitable both as a birth control method as well as a prophylactic against STIs and HIV.

Too often, healthcare providers only target women with information about condoms and other forms of family planning. Because of their relative powerlessness many women are unable to discuss contraceptive or prevention methods with their partners. It is therefore essential to develop strategies that specifically raise male awareness and encourage them to take the initiative, given that women may not be able to discuss contraception and SRH issues with their partners.

Condoms should be easily available—within clinics, schools, youth centres, sports clubs, and pharmacies. In some countries, male condoms are distributed for free through the public health system. However, free distribution does not necessarily mean free condoms. Many men report indirect costs, including long waiting lines, bureaucratic paperwork, and unpleasant interactions with judgmental or unfriendly staff.

Men need to feel comfortable coming to the clinic or health post for condoms. If they do they are more likely to return when they require other services. Confidentiality (not having to provide personal information just to retrieve condoms), speed of service, and respect are paramount.

Unlike women, men generally have a very limited range of contraceptive options. Offering a variety of condoms can help motivate men's uptake and can show clients that staff are truly dedicated to promoting condom use and other healthy behaviours (Hancock, 2004). If possible, services should provide a broad variety of condoms for distribution (different flavours, sizes, textures, etc.). Lubricants should also be offered alongside information about how to use condoms in ways that will augment pleasure and enhance satisfaction.

Services providers should demonstrate how to use condoms and provide male clients with an opportunity to improve communication and negotiation skills. It should not be assumed that every man knows how to use a condom—indeed; a very significant proportion of men may not have any sexual or reproductive health education whatsoever.

Staff should also be encouraged to speak to men about the female condom. The female condom is a polyurethane sheath or pouch, which lines the vagina and, like the male condom, it helps to prevent pregnancy, STIs and HIV. It is slowly becoming more widely available in most countries and can enhance both partners' pleasure as well as contribute to their safety. The female condom can also generate discussion about equitable roles and decision-making within the context of intimate male-female relationships.

BOX 8

A TRAINING CURRICULUM ON MEN'S REPRODUCTIVE HEALTH SERVICES

Engender Health, an international NGO, developed a three-part curriculum to provide a broad range of health care workers with the skills and sensitivity needed to work with, and to provide, reproductive health services to male clients. The first part of the curriculum is designed to assist health organizations and health care workers to overcome organizational and attitudinal barriers that may exist when initiating, providing, or expanding reproductive health services and programmes targeting men. It also provides basic information about a variety of reproductive health issues relevant to men. These include sexuality, gender, anatomy and physiology, contraception, and STIs.

The second part of the curriculum focuses on strengthening service provider ability to communicate with and counsel men about SRH issues—with or without their partners.

The final section provides information about diagnosing and managing reproductive health disorders in men. Topics include disorders of the male reproductive system, including infertility and STIs; SRH history assessment; and step-by-step instructions for performing a genital examination.

TO DOWNLOAD THE COMPLETE CURRICULUM (ENGENDERHEALTH. 2008. INTRODUCTION TO MEN'S REPRODUCTIVE HEALTH SERVICES - REVISED EDITION: TRAINER'S RESOURCE BOOK. NEW YORK), VISIT ENGENDERHEALTH'S WEBSITE: [HTTP://WWW.ENGENDERHEALTH.ORG/PUBS/GENDER/MENS-RH-CURRICULUM.PHP](http://WWW.ENGENDERHEALTH.ORG/PUBS/GENDER/MENS-RH-CURRICULUM.PHP)

CAMPAIGNS AND COMMUNITY MOBILIZATION

The degree to which service-level and education efforts are successful is linked to the extent to which positive messages about male involvement in SRH are also disseminated and absorbed at community and societal levels. Campaigns, for example, can encourage men to seek out SRH information and services and can also help to advertise what services are available and where. For out-of-school young men and other marginalized groups (see Case Study 1, for example), community-level efforts may in fact serve as the primary vehicle for SRH information and available services.

Influential public figures and community gatekeepers, such as religious leaders, can play an important role in campaign and community mobilization. As described in Case Studies 2 and 3, religious leaders can leverage their influence to promote positive messages about male engagement in SRH and encourage men and their partners to seek counselling and services for issues related to sexuality, relationships, marriage and parenting. Campaign and community mobilization efforts can also help to overcome men's fear and/or indifference and emphasize the importance of taking care of their health, as well as that of their partner.



CASE STUDY 1

COME ON IN!: ATTRACTING YOUNG MEN TO SERVICES IN RIO DE JANEIRO

(PROGRAM TYPE: GENDER SENSITIVE)

The above poster was part of a project to increase young men's use of health services in low-income communities in Rio de Janeiro. The picture and message is intended to deconstruct the idea that health posts are only for women and children or only for the sick. The picture depicts a young man being greeted at the door to a community health post and the message describes the post as a place where young men can ask questions,

take care of themselves and get condoms. The poster incorporates local cultural expressions including graffiti art and slang. It was painted as a mural on one of the outdoor walls of a community health post and printed on postcards which were distributed at community activities along with informational materials on available services.

FOR MORE INFORMATION: WWW.PROMUNDO.ORG.BR



CASE STUDY 2

TOGETHER FOR A HAPPY FAMILY, JORDAN

(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

Jordan's 'Together for a Happy Family' was an integrated campaign, which sought to mobilize males to support shared and informed decision-making about family planning with their wives.

The campaign promoted five main messages:

1. Men should discuss family planning with their wives;
2. Using family planning is consistent with Islam;
3. Modern family planning methods are safe, effective, and reversible;
4. Male and female children are of equal value;
5. Using modern family planning methods enhances the quality of life of the entire family.

The campaign enlisted religious leaders and Jordan's royal family prior to the campaign launch and throughout its implementation. To show his support, His Majesty King Abdullah agreed to have a photo of the royal family on the cover of nationally distributed family planning calendar. The Prime Minister and cabinet ministers also appeared at major public events while Islamic scholars wrote booklets informing readers that using family planning is consistent with the teachings of Islam.

Campaign messages were disseminated via three main channels—the mass media, community mobilization, and a national contest. TV and radio spots aired during prime time and featured religious leaders espousing support for 'Together for a Happy Family'.

Religious leaders discussed campaign themes during family programmes on TV and radio, responded to questions from the audience, and wrote newspaper articles in support of the campaign. Through major daily newspapers, the campaign launched a National Family Planning Contest, and offered a grand prize to motivate families to talk about family planning and to seek out more information.

To mobilize local communities, project staff trained teams of physicians, religious leaders, and social workers to discuss campaign themes with community leaders. These further disseminated campaign themes by discussing them with family, friends, and community members. A subsequent evaluation showed that Jordanian men and women reported improved knowledge regarding specific modern family planning methods and greater support for shared family planning responsibility.

SOURCE: JHU/CCP COMMUNICATION IMPACT, JAN 2003, NO 14. [HTTP://WWW.JHUCCP.ORG/PUBS/CI/14/14.PDF](http://www.jhuccp.org/pubs/ci/14/14.pdf) ACCESSED JANUARY 2010

CASE STUDY 3

THE MALE MOTIVATION CAMPAIGN, GUINEA

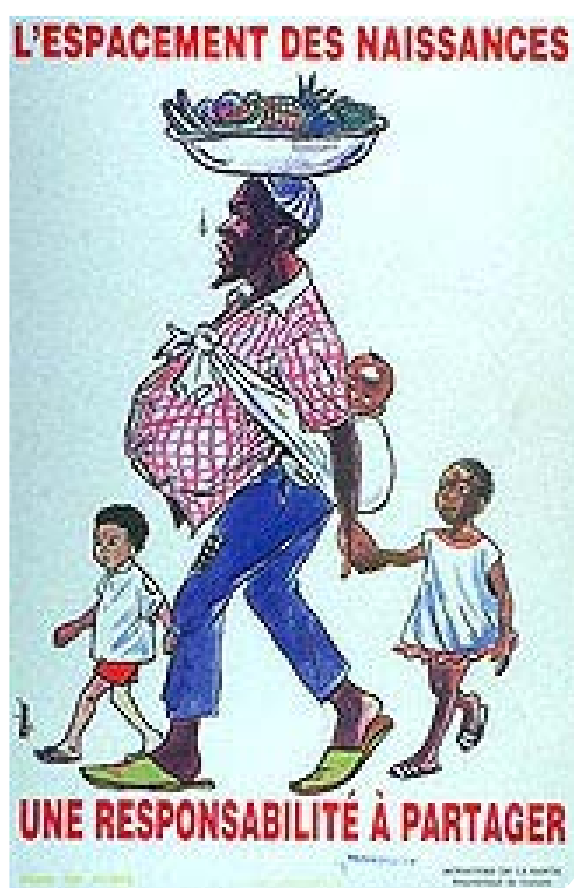
(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

The Male Motivation Campaign in Guinea sought to increase men's involvement in family planning. The first phase of the campaign included intensive advocacy work with religious leaders to attempt to gain social support for family planning. The second phase focused on married men and was designed to motivate them to talk to their wives about family planning and encourage them to use

available services. This latter phase included community mobilization and media activities, including the release of a short cassette and the broadcast of a short radio drama, which featured a popular local comedian who portrayed one husband's difficulty discussing family planning with his wife (Blake and Babalola, 2002).



TRANSLATION: CONTRACEPTION - A COUPLE'S BUSINESS



TRANSLATION: BIRTH SPACING - A SHARED RESPONSIBILITY

TOOLS

Education: Checklist for positive gender-equitable sex education for boys and men

Education: Understanding Sexuality

Services: Men's Reproductive Health Wall

Services: Values Clarification Exercise for Health Service Professionals



Although ways in which men can help alter gender-based healthcare inequities has drawn increased interest over the years, relatively little research, programme or policy efforts have focused on the role of men in maternal, newborn, and child health (MNCH)—including as fathers, husbands, and service providers (Carter and Speizer, 2005).

The period surrounding pregnancy, however, is now increasingly seen as an opportune time to engage and educate men about health in general and the well-being of their families in particular. Research has found that

expectant and new fathers are often particularly receptive to information that will ensure the survival and health of their babies. This corresponds to increased interest in acquiring information about their health and how risk-taking behaviours affect the welfare of others (Burgess, 2007).

More importantly, male involvement during the prenatal, newborn and early childhood period can lead to positive outcomes for fathers, mothers and children, including increasing the likelihood that the father will continue to participate in care giving throughout his children's lives (Burgess, 2007).

BOX 1

MATERNAL, NEWBORN AND CHILD HEALTH: AN INTERNATIONAL PERSPECTIVE

Maternal, newborn and child health refers to the health of women during pregnancy, childbirth and the postpartum period and the health of newborns and children under the age of five. Millennium Development Goal Five (MDG 5), which seeks to reduce maternal mortality by three-quarters by 2015, has shown the least progress of all the MDGs (Rosenfield et al., 2006).

It is estimated that over 529,000 women die annually from complications during pregnancy, childbirth, and the postpartum period while an additional 20 million women endure lifelong disabilities such as pelvic pain, incontinence, obstetric fistula, and infertility. Unsafe abortions account for approximately 13 per cent of all maternal deaths or about 68,000 per year (UN Millennium Project 2006). Nearly all of these deaths and disabilities occur in developing countries (UNFPA, 2005).

The fourth Millennium Development Goal (MDG 4) seeks to reduce the under-five mortality rate by two thirds by 2015. The leading causes of infant and child deaths—pneumonia, diarrhoea, malaria and measles—are easily prevented through simple improvements in basic health services and interventions, such as oral rehydration therapy, insecticide-treated mosquito nets and vaccination. Disparities in infant and child health outcomes across regions are significant—a child born in a developing country is over 13 times more likely to die within the first five years of life than a child born in an industrialized country. Sub-Saharan Africa accounts for about half of the deaths of children under the age of five in the developing world. (United Nations, 2008)

Persuading men to become more involved in MNCH can also redress broader gender inequities. Women often shoulder the burden of caring for children and domestic work. This is one reason why they both earn less and tend to be employed as part-time or informal labourers. It follows then that the more men are involved with childcare the more they will help to diminish these inequalities—both in the workplace and at home (Burgess, 2007).

Gender norms and inequities play a major role in maternal, newborn and child death and disability.

In many countries the low social status of women means many have hard time gaining access to the information and services necessary for a healthy pregnancy, birth and postpartum period. In many settings it is usually men who control the household income and who hold the decision making power in matters which can affect maternal health—whether it be with respect to access to social services or reproductive and contraceptive choices (IGWG, 2005; Orji et al., 2007). More critically, it is also often men who make the decision as to whether a woman can seek help if she develops complications during pregnancy, childbirth or soon after. Although men are often the principal decision-makers, many are unaware of the possible complications that a woman may experience during pregnancy and the post-partum period and may be unwilling or unable to talk to her about it.

Even where men do not directly obstruct a woman's access to services, the nature and extent of their participation throughout this period can influence the health experiences and outcomes of women in addition to those of newborns and children. For example, research has found that a father's presence (or, indeed, that of another close friend or relative) at the birth can help make labour and delivery a more positive experience for the mother (Burgess, 2008). Likewise, a mother's decision to initiate and sustain breastfeeding, a practice which has been linked to positive newborn and child health outcomes, can be influenced by the father's own attitudes about nursing (Burgess, 2008). **At the same time, it is important to recognize that male involvement in and of itself does not necessarily ensure more favourable MNCH outcomes—especially, if male behaviour is domineering and controlling (Carter and Speizer, 2005; Mullany et al., 2005).**

In many settings, men are still largely marginalized from MNCH-related services and activities. This can often be attributed to discriminatory attitudes among health providers or to men's lack of knowledge about MNCH and the important role they can play. Other reasons for their marginalization are often related to larger social and economic factors such as the inability of many men to take time off from work

to attend pre-natal sessions or newborn check-ups (Carter and Speizer, 2005). Barriers to take time off can be financial—particularly for those men who are paid on an hourly basis—or structural as in the case of those companies/employers who do not recognize that participating in pre-natal and newborn check-ups is a critical aspect of fathering. Moreover, and as discussed in the introduction, men are often less likely to seek health and social services owing to ideals of masculinity which dictate that seeking help is a sign of weakness.

If men do seek services, it is often because of concerns relating to sexual health—e.g. treatment for STIs or condoms. Health services, in turn, often do not take advantage of this opportunity to engage men in discussions about reproductive health or MNCH. Indeed, reproductive health and MNCH services are often female-oriented and service providers may be unaware of the importance of engaging men and/or of how to do so. Efforts may also be complicated by the fact that women may not feel comfortable in the presence of unrelated men if facilities have not been designed to accommodate both. As a result, clinic staff may be less welcoming to male clients.

There is little comparative data about the current nature and extent of men's involvement during antenatal, birth, and postnatal care services, nor with respect to societal expectations about men's involvement. Existing evidence suggests, however, that men support MNCH in varying degrees—ranging from accompanying women to health care visits to helping with household chores. A study of fathers in El Salvador found that 90 per cent had participated in at least one prenatal care visit, delivery, or a postpartum well-baby care visit (Carter and Speizer, 2005). Similarly, a study undertaken in four countries in Central America found that 96 per cent of male respondents agreed that it is important to support partners through the pregnancy and birth (Hegg et al., 2005). In Nepal, 57 per cent of women attending antenatal care at a large urban hospital reported that their husbands helped them to reduce their workload (in Mullany et al., 2005). In England, it is estimated that 86-98 per cent of fathers are present at the birth of their children (Kiernan & Smith, 2003; National Health Service, 2005 in Burgess, 2008). Moreover, research has also found that women prefer that men become more involved with maternal health (Mullany et al., 2005).

Research has also found that the reasons men may not be involved in MNCH are more often related to external or structural factors such as work demands, hospital regulations, and health provider attitudes than to men's perceptions of gender roles or negative attitudes about MNCH (Carter, 2002; Carter and Speizer, 2005). Moreover, a

variety of factors influence the experience of fatherhood and to what extent a man will become involved. These include the relationship with the mother and their age (see Box 2 Young Fathers and MNCH, for example) as well as cultural and social norms related to men and care-giving.

Finally, it is noteworthy that men's engagement in MNCH extends beyond fathers but also to brothers, in-laws, other male relatives, as well as male reli-

gious and community leaders. In some settings, male leaders can play a key role in discouraging child marriage, early childbirth and other local practices and traditions that may affect MNCH outcomes, including female genital mutilation/cutting. Because there is so little opposition with respect to discussions relating to motherhood and children, mobilizing men for MNCH can provide an entry-point for engaging them on other issues such as GBV and the education of girls (Kamal, 2002).

BOX 2

YOUNG FATHERS AND MATERNAL, NEWBORN AND CHILD HEALTH

Younger fathers often have a harder time getting involved with MNCH than older fathers. Families, service providers and other gatekeepers may not believe that young fathers are able or willing to care for their children.

Because many young fathers lack the necessary social and financial resources to take on the responsibility of childcare, MNCH services and programmes can be crucial. They can affirm a young man's identity as a father; encourage his participation in MNCH; provide information and counselling with regards to parenting skills and child development and address his anxieties and concerns regarding childbirth and parenting.

Many young fathers may also face rejection from their partner's family and may believe they are unwelcome and inadequate as parents. Young fathers who are not living with the mother of their children may also need specific information about issues such as birth registration and child support.

When possible, MNCH services and programmes should also seek to engage the young father's wider family (his own family and that of his partner) as well as his peers. Family and peers can play a key role in either facilitating or obstructing a young father's engagement with his child or children.

BOX 3

KEY ROLES MEN CAN PLAY IN MATERNAL, NEWBORN AND CHILD HEALTH

Plan their families: Men can discuss with their partners when and how many children to have. It is important that decisions are arrived at jointly and that men do not insist on more children than partners want.

Support contraceptive use: Men should also discuss contraceptive choices and preferences with partners and accompany them to see a family planning counsellor or attend health worker visits. The goal is to decide together which contraceptive method (or combination of methods) best meets the couple's needs.

Help pregnant women stay healthy: When his partner becomes pregnant, a man can encourage her to obtain proper antenatal care and offer to accompany her during clinic visits, provide transportation or funds to help pay for expenses. He can also take the time to learn to recognize the symptoms of pregnancy complications and make sure that his partner eats nutritious food, especially food high in iron and fortified with vitamin A.

Continue to be a respectful sexual partner: It is important that men (indeed, couples) have accurate information about sex during the different stages of pregnancy and postpartum. Although there are many preconceived notions and myths about sex during pregnancy, generally-speaking it is safe for a woman so long as her pregnancy is normal or low-risk. As at anytime in the relationship, however, men should respect whether or not his partner wants to engage in intimate relations. In some countries, the widespread belief that women cannot have sex during pregnancy and/or soon after often serves as a "justification" for a partner to engage in extramarital relationships.

Addressing the norms and myths that support these perceptions and types of behaviours is an important part of MNCH programming. Moreover, men need to be reminded that STIs can be harmful to mother and baby and can trigger premature labour and cause other serious complications. If there is any possibility that a man is infected he should use a condom.

Arrange for skilled care during delivery: Men can help to ensure that a trained attendant will be present during the birth by arranging ahead of time for transportation to a clinic or health post, identifying a blood donor in the case of an emergency, and arranging care for those children who will be left behind. For home births, men can help purchase necessary supplies and arrange for transportation in the case of an emergency.

Avoid delays in seeking care: Men can play a crucial role assuring that women receive prompt care by learning to recognize the signs of an imminent delivery and of potential complications.

Provide support during the birth: Another way men can help is by learning about breathing techniques and movements that can help alleviate the pain of delivery. Male partners can also make sure that their partner has enough food and drink and is adequately distracted between contractions.

He can also advocate on behalf of his partner to healthcare providers. The emotional support that a man can provide during birth is valuable and can help to transform the pain of birth into more positive experience for the woman.

Provide support after the baby is born: During the postpartum period men can provide extra support with housework and childcare. They can be directly involved in newborn care by changing diapers, bathing, putting them to sleep, burping, and even feeding when appropriate.

This early contact strengthens the father-child bond as well. They can learn how to spot potential postpartum complications and to seek help when they occur. Male partners can also help to ensure that the new mother is well nourished and can encourage her to breastfeed. Finally, men can begin using contraception, either as a temporary measure to make sure that subsequent births are adequately spaced or if no more children are desired, undergo a vasectomy.

Be responsible fathers: Men promote their children's health by ensuring that they are immunized, are well nourished, have access to clean drinking water and are well-cared for if they fall ill.

As role models, fathers can support their daughters' education, teach their sons to respect women and to treat them as equals, and encourage them to play an active role both within and outside the family.

SOURCE: DRENNAN, 1998

BOX 4

MEN AS ALLIES IN THE PREVENTION AND TREATMENT OF OBSTETRIC FISTULA

Obstetric fistula is a preventable childbirth injury that occurs when a woman endures obstructed labour for an extended period without a Caesarean or any other type of medical intervention to relieve it.

It is estimated that at least two million girls and women living in Africa, Asia and the Middle East are suffering with obstetric fistula, and that an additional 50,000 to 100,000 girls and women develop obstetric fistula each year (UNFPA, n.d.).

During obstructed labour, the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bone. The lack of blood flow causes tissue to die, creating a hole between the mother's vagina and bladder (known as a vesico-vaginal fistula), or between the vagina and rectum (a rectovaginal fistula) or both. The end result is that she is left leaking of urine or faeces or both.

Girls and young women between the ages of 10 to 15 years are especially vulnerable to obstetric fistula because their pelvic bones are not yet sufficiently developed to withstand childbearing and delivery. Fistula can generally be repaired

through a specialized surgery; however, most women with the condition do not know that the treatment exists or cannot afford it. Moreover, not all doctors can repair fistula—it requires training and in many poorer countries only a few hospitals offer the surgery.

In addition to physical health consequences, a girl or woman with fistula may also suffer social stigmatization. Men—as husbands, fathers, and leaders—can help prevent and treat obstetric fistula by promoting female education and empowerment, advocating against child marriage and other harmful practices, and access to family planning and appropriate and timely obstetric care.

SOURCE: WWW.ENDFISTULA.ORG

PROGRAMMING FOR ENGAGING MEN AND BOYS IN MNCH

Engaging men in MNCH requires a combination of services-based, education, and community outreach and advocacy efforts. On a services level, engaging men may involve training staff and adapting spaces and services so that they are more welcoming for men. On a community level, efforts should aim to change attitudes regarding men's involvement in MNCH, persuade decision-makers and local leaders to get involved and raise general awareness of couple and gender-friendly MNCH services that exist. Finally—as will also be discussed in this section—it is necessary to advocate for changes in the structures and policies (e.g. paternal leave) that often limit men's opportunities to participate in MNCH.

GROUP EDUCATION

In many countries, caring for children is viewed as an exclusively female domain and girls and women often practice and learn care-giving from an early age (e.g. caring for siblings, playing with dolls). Boys and men, on the other hand, most often learn that they need the skills necessary to become a good provider, but not necessarily caregivers. **Men and boys need an opportunity to develop the necessary confidence and skills to care for children.**

Because the concerns of a father may differ from that of the mother, programmers need to recognize differences and address needs separately. This can be accomplished in a variety of ways: including through couple's sessions where men and women divide for a short period to discuss their concerns separately

(Fisher, 2007). It is best to advertise these as services for both "mothers and fathers" and to avoid using the term "parent" which is commonly understood by both men and women to mean mothers only. Also, it is recommended to avoid using such terms as "group", "education" or "class": Advertising interventions as "how to" information sessions focusing on the baby is far more likely to attract fathers (Fisher, 2007).

Specific content will be discussed in more detail in the following section on services. Case Studies 1 and 2 present examples of education efforts undertaken outside the health services context. The following section discusses services-based strategies designed to serve as an entry-point to educate expectant fathers on MNCH issues.

CASE STUDY 1

BOOT CAMP FOR DADS

(PROGRAMME TYPE: GENDER TRANSFORMATIVE)

In the United States, a peer-led programme model called Boot Camp for New Dads invites small groups of expectant fathers to spend an afternoon with two or three "mentor fathers" who bring their babies with them.

A trained facilitator is present, but other than that, there is no curriculum or fixed list of issues to cover. Rather, the expectant fathers are simply given the opportunity to discuss their expectations and concerns with other fathers, and to witness practical baby care in action—changing nappies (diapers), cuddling, massaging, etc.

The role of the facilitator is also to identify those expectant fathers who could serve as mentor fathers to future groups. Proven successful in a wide variety of communities and settings, the programme works with and through maternity services, child health clinics, religious institutions, and in military bases. Over 150,000 men have participated to date and the programme has now expanded internationally to include Italy and Japan.

FOR MORE INFORMATION: WWW.BOOTCAMPFORNEWDADS.ORG



BOOT CAMP FOR DADS

CASE STUDY 2

FATHERS' CLUBS IN RURAL HAITI

(PROGRAMME TYPE: GENDER SENSITIVE)

The Haitian Health Foundation is supporting the creation of fathers' clubs in a bid to address family and child health issues in rural areas. Fathers meet regularly to learn about child health problems and how to solve them. Specific topics include: Early childhood nutrition, the importance of breastfeeding and routine infant growth monitoring, immunizations, homemade oral rehydration solution (ORS), and when and how to use it, and when and how to seek further professional help if a child is ill. Fathers also discuss how to support their wives with

childcare, share family-related problems and help each other when needed. The meetings are open to all men in the village, and are usually run by a village health agent together with a professional nurse. Participants use a variety of formats to present information and exchange ideas, including songs and skits. Fathers also participate in other health-related and community activities, such as assisting with health fairs (Sloand and Gebrian, 2006).

SOURCE: SLOAN AND GEBRIAN, 2006

GROUP EDUCATION

Personnel who staff MNCH services often view men as intruders or “outsiders”. Many service providers may see pregnancy as a woman’s domain and may have negative attitudes about male involvement. Programmers need to provide opportunities for service providers to reflect on their attitudes with respect to men’s involvement and their own related expectations and concerns. For example, Fathers Direct training courses for professionals in the United Kingdom rely on provocatively negative statements to stimulate debate and help participants explore their own attitudes about men and women and how these influence their interactions with mothers and fathers in service settings. Examples of such statements include: “A father cannot cope with children without a woman to help him”; “Fathers are not particularly interested in caring for children.” After a period of reflection, programmers discuss the proven benefits of male involvement on maternal and child health outcomes.

As discussed in the section on gender transformative programming, it is important that all services-based staff be offered an opportunity to participate in some kind of male involvement sensitization or training. As security guards and receptionists are often the first people a man will see as soon as he walks in the door, they should also be present in any of the “front-line” and are key to making men feel comfortable and welcome. Similarly, waiting and consulting spaces should also be welcoming—too often posters and brochures available only depict images of women and children. Services should seek to display images that challenge the stereotype of women as sole caregivers, and depict men in care giving roles.

In addition to building their own awareness, many service providers also need the necessary knowledge and skills to effectively engage men with respect to MNCH. They need to be prepared to address common concerns and questions—such as how to support partners, the effect of childbearing and rearing on a couple’s relationship and how to adjust to the demanding role of fatherhood.

At the same time it is also necessary for staff to reflect on, and be prepared for, the possible complexities and challenges involved in engaging men in MNCH. These include dealing with men who are controlling or violent (see Box 6 Dealing with Difficult or Violent Fathers) or organizing spaces in such a way that men can be at their partner’s side without intruding on the privacy of other women—particularly during labour.

In terms of services, prenatal care can provide fathers with an opportunity to learn about how they can assist their partners to prepare for a healthy pregnancy and birth. Service providers should encourage fathers

to attend prenatal sessions. For example: If a woman comes in for a consultation alone the provider can ask if she would like her partner to be invited into the room. If she comes to the clinic unaccompanied, the provider can ask if she would like to take home a signed invitation requesting her husband’s presence at the next session (see Tool “ Sample letter to invite men to pre-natal services”).

There are some MNCH services that can be particularly effective entry-points for involving men in prenatal care. For example, an ultrasound scan (when available) is now recognized an opportune moment to engage fathers: Seeing and listening to foetal movements can offer men a powerful physical link to the reality of the pregnancy and help them transition to parenthood. Some services may also offer incentives: For example, shop vouchers for couples who attend at least four antenatal sessions. It is important, however, to ensure that these incentives are locally appropriate and not unintentionally coercive or discriminatory towards single mothers.

Prenatal education for men should include the same information that women receive: Care and nutrition during pregnancy; pregnancy complications and what to do should the mother require emergency medical care; the importance of breastfeeding; fertility and postpartum family planning; in addition to postnatal and infant and child health and development. Service providers should also inform fathers of the negative health consequences of STIs during pregnancy and provide them with the necessary skills and methods to protect themselves and their partners. Service providers should also alert new fathers of the potential emotional impact of the postpartum period on their couple’s relationship.

The presence of the father during delivery is an important source of support for many mothers and also helps a father to more powerfully bond with the child. Service providers should encourage parents to discuss beforehand whether the father should be at the birth or not and what kind of support he will provide. If parents decide that the father will be present, service providers should instruct him on how he can be most useful and supportive, for example, by helping the woman with breathing techniques to help mitigate the pain or making sure she has enough water.

After the birth, service providers should make sure that both mother and father receive lessons about how to care for the baby. This includes bathing and changing diapers. Many fathers (particularly first-time fathers) for example, may fear that they are too clumsy to carry out these tasks—it is important that providers alleviate their fears and attempt to reassure them that men can learn to do these tasks as well as women.

Providers should also work with couples to identify and create opportunities for the father to regularly bond with the baby: For example by holding the baby for a sustained period while the mother sleeps or rests or burping the baby after feedings. Men should also be engaged during the post-natal period, including in-home visits. If the father does not live with the mother and child, service providers should make special arrangements with the mother to ensure he is included somehow (e.g. through follow-up telephone calls or the provision of informational materials).

Finally, it is important to remember that open-mindedness with regards to being present at the birth, sharing in childcare tasks, etc. is significantly influenced by community and cultural norms regarding respective male and female roles. Service providers should be sensitive to these and identify

the degree to which they should challenge the status quo in given context. For example, where men control female access to services, service providers should focus on sensitizing men to the importance of regular prenatal care, safe birth settings, etc. Where these services are only available on a per-payment basis, service providers will also need to persuade men that money for such services are well-spent. In such circumstances, efforts to encourage fathers to be present at the birth, share in washing, feeding and other child-care tasks may have to take a back seat to the more urgent priority of ensuring the basic health and well-being of mother and child. Moreover, efforts to change the status quo cannot be limited to the service-delivery level. As discussed later, it is also necessary to implement community and society-level action to shift attitudes and perceptions regarding male involvement during the prenatal, newborn and early childhood periods.

BOX 5

INVOLVING MEN IN THE PREVENTION OF PARENT TO CHILD TRANSMISSION (PTCT) OF HIV

Parent to child transmission (PTCT) of HIV is when the virus is passed from an HIV-positive mother to her baby. Although also known as mother-to-child-transmission (MTCT), the term parent-to-child-transmission recognizes that both men and women contribute to the transmission of HIV to children. While the immediate source of the child's HIV infection, during pregnancy, childbirth or breastfeeding, is the mother, she might have acquired HIV from her partner. It takes both parents to produce a child and responsibility of giving birth to a healthy baby lies with both.

Primary prevention of PTCT means that both parents have to protect themselves from HIV infection and practice family planning to avoid unintended pregnancies. Where the pregnant woman is already living with HIV, research has found that involving male partners can make a real difference in improving a woman's likelihood of using PTCT

services. When outreach efforts successfully engage men, they are far more likely to support women at critical turning points: Deciding whether to take an HIV test, returning for test results, taking antiretroviral drugs, and practicing safer infant feeding methods (Horizons, 2003).

A study in Nairobi, for example, found that when the partners of women living with HIV came to the antenatal clinic for Volunteer Counseling and Testing, mothers-to-be were more likely to receive nevirapine during follow-up, avoid breastfeeding their infant, and report condom use (Farquhar et al., 2004).

FOR MORE INFORMATION, SEE SECTION ON HIV/AIDS PREVENTION, CARE, TREATMENT AND SUPPORT.

CASE STUDY 3

PROMOTING THE RIGHT OF FATHERS TO BE PRESENT AT THE BIRTH OF THEIR CHILDREN

(PROGRAM TYPE: GENDER SENSITIVE)

In Brazil, there is a federal law which guarantees a woman's right to have a companion present before, during and after she gives birth. In practice however, this law is often ignored owing to a combination of negative health provider attitudes and a lack of awareness amongst the general population.

A study undertaken by Instituto PAPAI (Portuguese for father), a Brazilian NGO, found many inconsistencies among the maternity wards in the city of Recife in north eastern Brazil. Some only allowed female companions to be present, others only allowed male companions at the birth but not before or after and in many cases, it was left to the discretion of medical staff as to whether a male was allowed in.

TRANSLATION: THE FATHER IS NOT A VISITOR!
FOR THE RIGHT TO BE PRESENT AT DELIVERY.

In response, PAPAI organized a public demonstration calling on the government to enforce the law. NGO volunteers also distributed educational materials and engaged in street theatre to promote awareness of just how important fathers are to reproductive health and to childrearing.

FOR MORE INFORMATION: WWW.PAPAI.ORG.BR



BOX 6

DEALING WITH DIFFICULT OR VIOLENT FATHERS

Service providers occasionally encounter fathers who are difficult to engage or who are disruptive during clinic visits, the birth or at other moments. There can be many reasons behind such behaviour—from a sense of anxiety over impending parenthood to more serious emotional or relationship issues. When the problem is one that exists between the parents, the service provider should refer the couple to a counsellor, religious leader, or other professional if he/she does not feel prepared to handle couple conflict. Speaking with the father directly may help to resolve most minor issues; however, it is always useful to have a referral system with other organizations that are better equipped to deal with issues relating to drug and alcohol use, mental health and unemployment.

In situations where a father is violent towards a pregnant woman or child, service providers should be extra cautious and will need to deal with the situation with utmost care. Service providers should be trained in how to screen clients for signs of violence or abuse (LINK to Tool in section Gender Based Violence: Domestic Violence Assessment Guide) and know how to refer anyone experiencing violence or abuse to services that can provide the appropriate support. Providers should also be prepared to refer those men who want to change their abusive or violent behaviour to services that can assist them while, at the same time, report abuse to local authorities according to local or national reporting domestic violence guidelines.

CAMPAIGNS AND COMMUNITY MOBILIZATION

In addition to making services more inclusive and friendly, providers should try to reach fathers outside of the services setting. Safe motherhood initiatives undertaken in rural India, for example, have successfully reached men by hiring male health workers. These health workers accommodate their outreach efforts to the work schedules of the men they are trying to reach. An evaluation of the initiative revealed that the number of men seeking out health workers to register their wives for early antenatal care increased—as did the number of husbands accompanying women to hospital, and the number of fathers bringing their young infants in for immunization. The primary reason the initiative was so effective, according to the evaluation, is that many Indian men consider a visit from a male outreach

worker as being far more significant than visits by regular midwives, and thereby attach greater importance to them (Raju and Leonard, 2000).

In addition to reaching large numbers of men with messages and information about how to support maternal and child health, campaigns can also help to contribute to changes in community and social norms. A good example of this is Case Study 5, an Indonesian campaign that was designed to promote safe pregnancy and birth by engaging men. Campaigns can also seek to change public policy and laws by advocating, for example, that fathers be allowed to be present at the birth (see Case Study 3) or that they be granted paternity leave (see Case Study 6).

CASE STUDY 4

A WORLDWIDE CAMPAIGN TO ENGAGE MEN AS PARTNERS IN MATERNAL HEALTH

(PROGRAM TYPE: GENDER SENSITIVE)

On World Population Day in 2007, UNFPA organized a series of activities and events worldwide under the theme: Men as Partners in Maternal Health. The aim was to highlight how the participation of men can improve maternal health.

Campaign organizers used “Men at Work” as the slogan and made sure that all campaign activities and events highlighted a common message: That male participation is vital to the promotion of reproductive health, development and the well-being of families and communities. Campaign activities ranged from TV spots in Mongolia to a live radio-television debate in Rwanda in which representatives from the Ministry of Health, Ministry of Finance and Economic Planning, National Women’s Council discussed the importance of male involvement in maternal health and family planning.

FOR MORE INFORMATION: WWW.UNFPA.ORG



CASE STUDY 5

SUAMI SIAGA: THE ALERT HUSBAND CAMPAIGN IN INDONESIA

(PROGRAM TYPE: GENDER SENSITIVE)

Suami SIAGA (Alert Husband) was an Indonesia-based mass media campaign designed to involve husbands in pregnancy prenatal care and to prepare them for any potential emergencies. SIAGA means: "alert" and is also an acronym for Siap (ready), Antar (take, transport), and Jaga (stand by or guard).

Campaign components included:

- The production of a number of new episodes of an existing radio drama series that contained specific messages about "alert" husbands;
- An educational television mini-series that carried messages about safe motherhood; brochures and stickers; interpersonal communication materials developed for service providers;
- Community mobilization activities designed to facilitate the multi-media campaign; and
- A variety of supplementary materials and resources such as T-shirts, hats, pins, and broadcasts via mobile van.

Mass media components of the campaign (i.e., radio and television broadcasts) reached a national audience, but the remaining project components were implemented in selected provinces.

An evaluation undertaken after the campaign found that husbands who were exposed to print media were five times more likely to report taking action than men who were not exposed to the campaign.

Husbands who participated in interpersonal communication about becoming a Suami SIAGA were ten times more likely to report taking action, such as making arrangements for safe childbirth. A number of follow-up SIAGA campaigns focused on other audiences including community members and midwives – all of whom play a critical role in facilitating a safe pregnancy, delivery and postpartum period.

The poster above shown here describes specific ways in which husbands can support pregnant wives and thus ensure a safe and healthy pregnancy and delivery. Translation: (SIAP: On guard and act when you see dangerous signs of pregnancy; accompany your wife to a midwife for a pregnancy check (minimum 1 x in the 1st quarter, 1 x in the 2nd quarter, 2 x in the 3rd quarter); ask for help from the community when your husband is not available. ANTAR: Always prepare a transportation system, blood donor. JAGA: Accompany your wife at the time of, and following, delivery).

CASE STUDY 6

GIVE ME LEAVE, I AM A FATHER: PROMOTING PATERNITY LEAVE IN BRAZIL

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

In 2008, a network of Brazilian NGOs launched a campaign to advocate for an expansion of the current paternity leave of five days to at least one month²². In addition to producing video spots, posters and other media pieces, campaign personnel organized a series of public debates to bring together government and civil society to discuss the importance of extending paternity leave. The campaign also encouraged fathers to take the leave to which they were already entitled.

FOR MORE INFORMATION:

WWW.PROMUNDO.ORG.BR OR WWW.PAPAI.ORG.BR



TRANSLATION:
GIVE ME LEAVE, I AM A FATHER!

TOOLS

Education: The Baby is Crying

Services: Sample letter to invite men to pre-natal services

Campaigns: Promoting men's role in safer motherhood

***FOR ADDITIONAL TOOLS ON WORKING WITH MEN AND BOYS IN THE PROMOTION OF CHILD HEALTH, PLEASE ALSO REFER TO THE FATHERHOOD MODULE (NEXT).**



Research has found that fatherhood is a central experience in the lives of many men and can have numerous benefits for children, women and for men themselves (See Box 1 Why being a father matters). Multi-site studies, however, reveal that fathers contribute only about one-third to one-fourth as much time directly caring for their children as women do (Population Council, 2001). In many settings, fathers are usually responsible for disciplining or passing on skills to children, but are not caregivers. **Indeed, caring for and raising children is very often perceived as a female role.** Even in those settings that are considered more gender equitable, women are still perceived as natural care-givers.

The widely held association between women and care giving is rooted more in social constructions regarding male and female roles than their innate capabilities. For example, in many societies girls will spend most of their time in the home helping with household chores and taking care of younger children. Even when girls play, they are often provided with toys that emphasize care-giving and domestic chores, either by playing with dolls or playing at cooking or serving meals (ex. tea parties). On the other hand, boys tend to be encouraged to play outdoors and are discouraged from playing with dolls or engaging in other “feminine” games.

As they get older, boys are pushed more and more towards what are widely considered to be “masculine” games, such as sports or playing with cars, trains, toy guns, or into male household activities, such as helping their fathers fix things around the home. Boys are rarely encouraged to care for smaller children in the same way that girls are or to take part in domestic chores. It is important to emphasize, however, that this division of roles is learned and can vary substantially between

countries and different cultures as revealed by the example of the Aka people in Box 2.

Many existing policy and programme initiatives are based on idealized, normative or moralistic views of what being a father means—**notions that may not be conducive to promoting family or child well-being or gender equity.** For example, while made up of men with valid grievances, a number of fathers' rights groups (generally divorced or separated fathers seeking greater visitation or cohabitation rights) often espouse a traditional notion of an “intact” biological family or patriarchal notion of fatherhood. Many of these groups are fuelled more by anger at ex-partners than genuinely interested in gender equity (Flood, 2004).

Other fathers' groups have emerged out of a genuine and laudable desire for closer relationships with their children. Only a handful of these initiatives, however, support true gender equity: i.e. engaging men to share domestic chores, childcare duties, and child support. Fewer still are initiatives that seek to promote cooperation between co-parents, regardless of their marital or relationship status.

When discussing fatherhood, it is important to recognize that the term encompasses a wide variety of men. For example, fathers may be living with and married to the biological child's mother; they may be married to another woman and still live with their biological child; they may live with their partner and her children yet have biological children that live with their mother or they may be a single parent of their own biological child(ren). Others may live alone and only visit their biological children. In sum, there are a plethora of ways in which men experience and live out the role of father. In the literature, distinctions are often limited to

residential versus non-residential and biological versus non-biological fathers. These do not take into account various types of fathers, including men who adopt and those who are not fathers in the traditional sense but who may find themselves in fathering roles (uncles, grandfathers, etc).

Finally, laws and policies related to child support, divorce and children's rights may also significantly influence how men father. The provision of paternal leave (depending how it is implemented) has been

shown to directly impact men's involvement in early childhood (Lewis & Lamb, 2007). Public health system policies and practices also influence to what degree fathers are allowed or encouraged to be present at the birth of their children or to participate in their care— although these issues have seldom been studied (Population Council, 2001; Lyra, 2002). Child support and other types of laws, which recognize the rights of children born outside of formal unions, also have an impact on men and their participation as fathers, even if, again, systematic research on the issue is scarce.

BOX 1

WHY BEING A FATHER MATTERS

Research in Western Europe and North America shows that when men (either as social fathers or biological fathers) participate their children's lives, the latter benefit in terms of social and emotional development, often perform better in school and have healthier relationships as adults. Indeed, research from the U.S. and other settings—particularly those which are stressed and resource-poor— confirms that having multiple, supportive caregivers, regardless of their sex, is probably the most important determinant of child well-being (NCOFF, 2002; Lewis & Lamb, 2003). It is important to clarify, of course, that the positive benefits of a father's presence are dependent on the positive quality of his presence.

Father or male presence, other things being equal, helps to increase household income. Research in diverse settings confirms that families which have a man or father present in the household, or a non-residential father who provides child support, generally enjoy higher household incomes, even if men on aggregate provide a smaller percentage of their wages to the household than do women.

The greater participation of men in childcare and domestic tasks is generally good for women. Men's participation in domestic chores, including childcare, and their positive participation in child and maternal health are generally beneficial for women. It allows women to work outside the home and to study or to pursue activities that generally lead to a better quality of life both for themselves and family members.

Being an engaged father and caregiver is generally good for men themselves. Men who are involved in meaningful ways with their children report this relationship to be one of their most important sources of well-being and happiness. Various qualitative studies suggest that men who are engaged in caring and care-giving relationships, including fatherhood, may be less likely to indulge in certain risk behaviours (such as criminal activity). The anticipation of fatherhood and the high esteem that comes from shouldering new responsibilities can help motivate behaviour change related to health and gender-equity (Scalway, 2001; UNAIDS, 2000).

BOX 2

AKA TRIBE

The fathers and mothers of the Aka, an ethnic group in Central Africa, are notable for the fact that they equally share care-giving responsibilities. In fact, in comparison to fathers in many settings and cultures, the Aka men are known for dedicating the most amount of time for the care of their children, spending up to 47 per cent of the time within arm's reach.

Men, for example, take their small children with them when they go foraging or hunting for food, even allowing them

to suckle at their breasts to placate them. In many ways, men's and women's roles among the Aka are practically interchangeable. Though women are still the primary caregivers, men and women take on different roles without any stigma or loss of status. Women can hunt and men cook and vice-versa and they slip into and out of these roles naturally (Hewlett, 2005).

BOX 3**ADOLESCENT AND
YOUNG FATHERS**

Providing adolescent and young men with the necessary information and skills to avoid unplanned pregnancies is an utmost priority (see section on Sexual and Reproductive Health). At the same time, providers should be careful not to assume that all adolescent and young men who became fathers were "careless". Some qualitative research in Chile (and other countries) has shown that adolescent pregnancy is not always feared and unwanted, but sometimes planned and anticipated by both the father and the mother (Aguayo and Sadler, 2006).

For many adolescent or young men, becoming a father represents a major role transition, a significant new relationship in their lives, and a new social function. However, all too often, adolescent or young fathers are often presumed to be negligent, irresponsible, and likely to shirk their duties as parent. Their own parents, the parent's of the child's mother, the mother herself and service providers may often discriminate and assume the worst. The adolescent or young father who does not marry the mother is often seen as being irresponsible, regardless of the fact that his motivations for not doing so are often more complex.

In some cases, adolescent or young fathers may want to be involved with their children but are prevented from doing

so by the child's mother or by her family. In other cases, the adolescent or young fathers may feel that, since they are unemployed and cannot provide financial support for the child, they do not have the right to interact with him or her. Indeed, research has found that adolescent and young men may initially deny responsibility and paternity when faced with a possible pregnancy because of the financial burden of childcare (Olavarria, 2002).

While much of the discourse about early childbearing—among adolescent young women and men—has focused on the negative consequences, which can indeed be very real, there is also positive a side that should be considered. For some adolescent and young fathers, parenthood can be a time to organize their lives, and can sometimes serve as a catalyst or pathway to becoming a more productive adult (Barker, 2001). Research in Rio de Janeiro, Brazil, for example, identified cases of young men who left gangs because of fatherhood and describe their child as their "life cause". One gang-involved young father said: "My daughter just pulls at my heart... she makes me want to change. She pulls me up. I feel like my daughter is my purpose to live. I want to be able to give her more" (Barker, 1998).

**PROGRAMMING FOR ENGAGING MEN AND BOYS IN FATHERHOOD
AND CARE GIVING**

Numerous assumptions hinder efforts to engage men and boys with information and skills and other forms of support related to fatherhood and care giving. Educators, service providers, policymakers and other gatekeepers often assume that fathers are not interested in their children, or in any case less interested than women. They may believe that fathers are generally incompetent or inferior to mothers as caregivers and/or that fathers are more difficult to reach than mothers. Multi-site studies, however, have confirmed that fathers are able to interpret and be sensitive to children's needs as well as mothers (Davis & Perkins, 1995; Lewis & Lamb, 2003) and that they are indeed open to efforts that seek to support them as fathers.

GROUP EDUCATION

Caring is a skill that is learned. However, many boys and men do not have the opportunity to acquire it owing to social and gender norms which associate care giving with girls and women. Parents, teachers, health educators and others need to provide boys and men with opportunities to deconstruct the notion that men are neither capable nor interested in care giving. These kind of reflections as well fatherhood coaching happen in the context of group education. Examples include support groups for fathers, informational and

skills-building sessions for first-time (or new) fathers or fathers in general (see Case Study 1), as well as sessions that encourage boys and young men to reflect on what it means to be a father and a caregiver in general.

Group education activities may work with fathers in male-only sessions or mixed groups. Both male-only and mixed groups have benefits: mixed groups allow men and women to work together on their co-parenting skills, whereas father-only groups make some men feel

more comfortable sharing some of their concerns and insecurities regarding parenting.

Skills building through role playing and modelling different situations represent an important aspect of fatherhood education programmes. This includes how to handle the news of becoming a father for the first time (See Tool "You're Going to Be a Father"), changing diapers, bathing and feeding small children and caring for their health, etc. (See Tool "The Baby is Crying" from the previous section, Men and Maternal, Newborn and Child Health).

Education activities should help men to question the gender norms that perpetuate the division of care giving roles and that make men, and women as well, perceive domestic chores such as cooking, cleaning or caring for the child's needs as primarily the woman's responsibility. This questioning and reflection process, however, is not always an easy one—in many circumstances, even when men take on domestic chores they may view their role as only "helping" their partner with the chores. Facilitators should encourage participants to reflect on their own relationship with their fathers—recognizing that men often need to consider their own experiences and attitudes about fatherhood before they can engage others on the issue, or consider their own (future or present) role as father.

Education programmes should also emphasize the importance of a father's participation in the lives of his children irrespective of his relationship with the children's mother or their family/living arrangement. Many programmes that work with divorced/separated fathers include discussions and activities about how to build or maintain a healthy relationship with their ex-spouse, including how to negotiate conflict and how to parent in an acrimonious environment.

One of the greatest challenges often standing in the way of parenting is whether a father can provide financially for his children. A few fatherhood programmes in the U.S. and Western Europe have incorporated job-skills training or vocational counselling to assist low-income and un- or under-employed men. Some of these are motivated by the goal of assisting (or obligating) fathers to pay child support rather than simply encouraging increased father-child interaction. Other programmes for low-income fathers have offered a mix of job training with counselling and fatherhood development. Limited evaluation reveals that a number of participants found employment and began paying child support (Watson, 1992).

CASE STUDY 1

FATHER SUPPORT PROGRAM, TURKEY

(PROGRAM TYPE: GENDER SENSITIVE)

The Father Support Programme (FSP) aims to help fathers play a more effective and positive role in the lives of their children. Participating fathers are taught about child development and are encouraged to improve their communication skills so that they will become better parents.

FSP is made up of 15 three-hour sessions that are participatory and designed to allow fathers to share their experiences. Group facilitators participate in training

seminars conducted by AÇEV and undergo a series of observation, supervision and feedback sessions during the implementation of the sessions with fathers.

The Father Support Programme is a project of the Mother-Child Foundation or Anne Çocuk Eğitim Vakfı in Turkish, hence its acronym AÇEV (pronounced AH-Cheff).

FOR MORE INFORMATION: WWW.ACEV.ORG

CASE STUDY 2

WORKING WITH INCARCERATED FATHERS IN THE USA

(PROGRAM TYPE: GENDER SENSITIVE)

Many incarcerated men are also fathers. Although in prison, it is still possible for these fathers to still play an important role in their children's lives—both while incarcerated and upon their release. Moreover, maintaining their identity and participation as fathers can serve as a valuable psychosocial outlet during their incarceration and can give them a reason to prepare and plan for a future on the outside. Active involvement in fatherhood can prevent many from returning to crime—

many programmes targeting incarcerated fathers cite decreased recidivism as an important reason behind such programming and also an indication of its success. The InsideOut Dad project of the National Fatherhood Initiative (www.fatherhood.org) is a 12-session curriculum that focuses on both English and Spanish speaking inmates. Its aim is to help inmates engage with their children on the outside and prepare them for parenthood upon their release.

CASE STUDY 3

HEAD START, USA

(PROGRAM TYPE: GENDER SENSITIVE)

Head Start are government-led programmes, which provide comprehensive child development services to low-income children who are entering the formal educational system—frequently when they are still in kindergarten. Although these programmes have traditionally focused on women as the primary caregivers, they are now increasingly seeking to include fathers, or male figures that play a parenting role, in their activities. Staff members consistently invite fathers to participate in all aspects of the programme

(e.g. interacting one-on-one with fathers to keep them involved) and display positive images of fathers and men in the classrooms. Evaluations of these strategies, together with others, have found that more fathers are getting involved in Head Start programmes and that the number who report being highly involved has increased.

FOR MORE INFORMATION: WWW.NHSA.ORG

HEALTH AND SOCIAL SERVICES

Within the health sector, only a very few initiatives have focused specifically on engaging men as fathers. One example was discussed in the section on Maternal, Newborn and Child Health (MNCH) – that of the campaign in Brazil which seeks to raise awareness among health professionals about the right for a partner to be present at the birth of their child. The section on MNCH also includes other strategies for engaging men as fathers—although most of them are focused on working with new fathers and providing information and skills related to the care of newborns and young children. Few programs work with fathers of older children and adolescents.

In addition to health services, there is a need for other services (schools, day-care centres, etc.) to more systematically provide fathers and men in general with information and supports related to parenting.

Moreover, there is a need to also engage men in care-giving occupations within services. Part of encouraging the greater participation of men as fathers is increasing expectations regarding men as caregivers in society as a whole. Men are often the minority among professionals in primary schools, day-care centres, nursing homes and other care-giving institutions. Encouraging men to participate in traditionally female care-giving occupations is an important step toward promoting the perception of men as caregivers and their participation as fathers.

CAMPAIGNS AND COMMUNITY MOBILIZATION

Campaigns and community mobilization efforts should seek to promote awareness about the benefits of involved fatherhood and challenge perceptions that reduce the role of men to financial support and/or discipline.

Campaign and community mobilization efforts should also address:

- The importance of men assuming their paternity when the pregnancy is outside of a committed relationship;
- The need for men to be involved from early infancy in the care of children; and
- The equal division of domestic chores and care giving.

Long working hours and a lack of paternity leave often prevent men from spending time with their children. Campaign and community mobilization efforts therefore should also seek to engage employers and policymakers with respect to paternity leave (see Box 6 below and Case Study 6 in MNCH chapter, for example) and other strategies to help men participate more in the lives of their children. These include flexible hours that will allow them to attend parent-teacher meetings, take children to doctor's appointments, etc.



BOX 4**PATERNITY LEAVE POLICIES**

Policy and legislation can play a critical role when it comes to encouraging and supporting fathers to become more involved with parenting and more gender-equitable relationships. In Iceland, no distinction is made between paternity and maternity leave—a nine-month paid leave (at 80 per cent of the salary) is split into three months for the mother (non-transferable), three months for the father (also non-transferable) and three months to be taken by either the father or mother (ILO, 2007).

This policy has led to some encouraging changes: In three years after the implementation of the law the average number of days taken by fathers increased from 39 to 83 (ibid.). In Sweden, couples with new babies are entitled to a total of 480 days of paid leave—the cost of which are shared between the employer and state. At least 60 of the 480 days are forfeited if not taken by the second parent. In 2002, men accounted for 15 per cent of the parental allowance, an increase from 12 per cent two years earlier. While still unequal, the burden is more equitably shared than in other countries where it is the mother only who takes leave (Björk, 2004).

While this degree of government and private sector support may not always be possible in low-income countries with limited state resources, the experience in Brazil suggests

this need not be the case. Several Brazilian states now offer one month of paid paternity leave to civil servants. Legislators are also debating a national law, which would grant all fathers 30 days of paid paternity leave upon the birth (or adoption) of their child.

Policy and legislative initiatives such as these help to promote the idea that men have a significant role to play and should have the opportunity to participate more closely in the lives of their children. Initiatives that are designed to balance the participation of women and men in caretaking responsibilities can also serve as important step toward levelling the playing field with respect to income disparities and unequal career opportunities experienced between men and women.

At the same time, it is necessary to keep in mind that the reach and impact of parental leave policy may be limited in low- and middle-income countries owing to the fact that the bulk of the labour force is often informally employed and will not be able to access such benefits.

(TEXT ADAPTED FROM ESPLN, 2009)

BOX 5**REACHING FATHERS
THROUGH THE INTERNET**

The Internet can be a powerful medium through which to reach fathers. In one study undertaken in Sweden, 65 per cent of parents report browsing a parenting website as their first resource. This points to the potential benefits of utilizing the Internet to target fathers. One of the few scientific studies focusing on an Internet-based intervention revealed that new fathers using the New Father's Network website reported significantly greater satisfaction and im-

proved self-efficacy in comparison to the control group (that did not use the site) during the first eight weeks following the birth of their child (Hudson et al., 2003). Although the majority of Internet-based outreach efforts are currently only available in industrialized countries, these could become increasingly relevant in developing countries as Internet accessibility and computer literacy continues to increase.

CASE STUDY 4

NYC DADS USA

(PROGRAM TYPE: GENDER SENSITIVE)

NYC DADS is a citywide initiative of the New York City Human Resources Administration/ Department of Social Services (HRA) that focuses on the important role fathers play in their children's lives. As part of this campaign, HRA has created a resource website (www.nyc.gov/nycdads), and hosts events throughout

the five boroughs to encourage dads with limited financial resources to spend quality time with their children. NYC DADS also endorses participation in parenting programmes that assist men in meeting their financial and emotional responsibilities in positive and meaningful ways.

TOOLS

Education: You're Going to Be a Father

Education: Division of Labor and Childcare in the Home

Education: Men, Women and Caregiving

*FOR ADDITIONAL TOOLS ON ENGAGING MEN AS FATHERS, PLEASE ALSO REFER TO THE PREVIOUS SECTION ON MNCH.

**HIV And AIDS
Prevention, Treatment
Care and Support**



Gender inequality remains one of the major drivers of HIV around the world. Among young people in sub-Saharan Africa, for example, HIV prevalence is considerably higher among females. In Asia, a significant proportion of new infections are occurring in women—many of whom have been infected by husbands or regular partners (UNAIDS, 2008). Addressing the rigid gender norms and unequal power dynamics that make women (as well as men) vulnerable to HIV is therefore essential if the epidemic is to be halted. There is a particular need to scale-up efforts that also engage men and boys (UNAIDS, 2008).

Most HIV infections are transmitted through heterosexual intercourse. Women are more likely to acquire the disease owing to a combination of biological and social factors (UNAIDS, 2008). The risk of women contracting the HIV virus during unprotected vaginal intercourse is two to four times greater than for men and this physiological vulnerability is further heightened by inequitable social norms that appear to condone forced or coerced intercourse.

Sexual coercion and violence are associated with decreased condom use and in the case of forced sex, the increased likelihood of HIV transmission due to possible injury to the genital tract and anus. Violence can also interfere with a woman's ability to access services—including testing and treatment—maintain adherence to antiretroviral (ARV) treatment, or carry out her infant feeding choices.

Many women suffer violence or are thrown out of the house when they reveal their HIV status to their husbands who often blame them for bringing HIV into the home. Sex workers are also highly vulnerable to HIV. This is because their low social status makes

them unable to negotiate condom use and or access to information and services. Cross-generational sex and other norms also contribute to the relative vulnerability of women and girls and highlight to what degree power inequality underpins the epidemic.

For men and boys, sexual experience is often associated with initiation into a socially recognized manhood, or as proof that they are "real men". Having multiple sexual partners is also perceived as a sign of virility: In many countries men report having significantly more sexual partners than women (Wiederman, 1997).

Coupled with the fact that HIV is more easily transmitted sexually from man to woman than from woman to man, the fact that a man often has more sexual partners than a woman means that a man with HIV is likely to infect more persons than a woman with HIV. Just as gender norms influence motivations and decisions around sex—they also influence decisions and behaviours related to prevention. Although condom use has increased in much of the world, particularly among young people—there are still significant numbers of individuals who do not use a condom consistently (UNAIDS, 2008). This is mainly due to a lack of information and skills regarding the correct use of condoms; low risk perception; dislike of condoms; lack of communication between partners about matters related to sexuality and; rigid social norms which associate condom use with lack of manliness or trust between partners.

In nearly all regions outside of sub-Saharan Africa, men who have sex with men (MSM) are among the groups most disproportionately affected by HIV, along with injecting drug users and sex workers (UNAIDS, 2008). MSM remain seriously underserved, however, with respect to HIV prevention services. In some countries, only 40 per

cent of MSM report knowing where to go for an HIV test and having been given a condom in the previous year (UNAIDS, 2008). Moreover, due to widespread stigma and the fact that sex between men is criminalized in many countries, it is likely that the prevalence of HIV amongst MSM is significantly underreported and not accurately reflected in epidemiological data.

The vulnerability of MSM also leads to increased vulnerability in the wider population. Many MSM also have sex with women—acting as a “bridge” into the heterosexual population. Health programmes and services do not make the effort to reach out to MSM. Therefore, more research is needed to understand how to provide appropriate HIV prevention, treatment, care and support for MSM. Stigma, discrimination and fear of public exposure in many countries means that MSM are less likely to access appropriate services than other groups (UNAIDS, 2009).

Injecting drug use is on the rise worldwide and is also a major driver of the HIV epidemic in most countries outside of Africa and Latin America. This is owing to the behaviour itself but also to stigma and the lack of services. The greatest numbers of people who use injecting drugs are found in China, Russia and the United States and, with Russia and Ukraine seeing the greatest increase with a 1–5 per cent prevalence rate (UNAIDS, 2008). According to current estimates approximately 37 per cent of Russian injecting drug users are HIV positive (Mathers et al., 2008). Drug use is higher among men (though it is rising among women) and is highly associated with male attitudes toward risk-taking.

Finally, gender norms and inequities also affect those who receive and provide HIV care and support. Worldwide, women and girls shoulder a disproportionate share of caregiving. Girls are increasingly pulled out of school to take care of sick family members and to assume household responsibilities previously carried out by their mothers. Elderly women often take care of grandchildren orphaned by AIDS, finding themselves emotionally and physically taxed by tasks usually performed by much younger women (Peacock, 2003). Studies from the Dominican Republic and Mexico found that married women with HIV often return to their parents' home because they are unlikely to receive adequate care from their husbands (Rivers & Aggleton, 1998).

Research in Tanzania and South Africa has found that the fear of being ostracized and ridiculed by other men in the community is one of the major factors which inhibits men from being more actively involved in care and support activities (Aggleton and Warwick, 1998; Kruger, 2003). Another barrier is the fact that men often lack the necessary knowledge and skills about how to support and care for people living with

HIV and AIDS. In general, however, there has been very little research about men's attitudes towards care and support and very few interventions have encouraged and empowered them to play a more active role in AIDS care and support (Peacock, 2003).

BOX 1

YOUTH AND HIV AND AIDS

In 2007, an estimated 45 per cent of new HIV infections in adults occurred in young people under the age of 25 (UNAIDS, 2008). Underlying this specific vulnerability is a number of factors—including continued lack of knowledge and misconceptions about HIV transmission, the lack of consistent and correct condom use, higher STI rates and unequal gender relations. Moreover, the rights of youth are often not respected, particularly with regards to access to information and services related to sexual and reproductive health.

Gender norms can interact with age in different ways to compound the vulnerability of youth to HIV. In many settings, the role of intergenerational sex in HIV transmission, for example, has contributed to increasingly higher rates of infection among girls and young women. As a result of having had more sexual partners older men are more likely to be HIV-positive, and are therefore more likely to transmit the disease to younger partners.

In many of the highest prevalence countries married women are generally 5 to 10 years younger than their husbands and are among the most vulnerable to HIV and AIDS. This is because married couples are less likely to use condoms owing to the pressure to have children, familiarity but also to unequal decision-making power owing to age differences (Clark et al., 2006).

Young men, on the other hand, are often more likely to use alcohol and other drugs, including injection drugs (UNAIDS, 2008). Sharing used needles is the most efficient way to transmit HIV and is the major driver of the epidemic in Eastern European countries and a major contributor in some parts of Southeast Asia (UNAIDS, 2008). Alcohol and drug use is also linked to an increased likelihood to engage in unsafe sex and can increase risk among young people.

Compared to older MSM, many young MSM are also at increased risk owing to greater social exclusion from services and support networks that can help them to protect themselves from HIV.

BOX 2

MEN ON THE MOVE: MOBILE POPULATIONS AND HIV RISK

Mobile populations, including migrants, refugees, truckers, migrant mine workers, and others help to drive the spread of HIV (and other STIs) in many settings. Male migrants often spend extended periods away from their wives and children. Distance from their families and a lack of traditional constraints on their behaviour may lead them to engage in commercial sex or extra-marital relationships.

Truck stops, mining towns, and other places, in which mobile men may pass through or live, often become hubs for commercial sex work as local residents (often living in impoverished circumstances) seek to earn money. Transient workers and illegal immigrants are also particularly vulnerable to HIV because they may not be able seek preventive care or treatment for fear of deportation or prosecution (Gutmacher, 2003).

ENGAGING MEN AND BOYS IN HIV AND AIDS PREVENTION, TREATMENT, CARE AND SUPPORT

To date, programmes and services have had only a limited impact on male HIV-risk behaviours and—by extension—the overall vulnerability of everyone to HIV infection. One reason for this is that HIV programmes have focused mainly on providing information despite the fact that diverse studies show this alone is not sufficient to promote lasting and meaningful changes in sexual attitudes and behaviours (Boler & Aggleton, 2005).

Rather, it is only a first step towards real behavioural change. Other factors, such as communication

and negotiation skills, access to services and SRH commodities, peer influence, gender attitudes, and desensitization to risk, generally guide if, when and how a man acts upon his knowledge.

Another reason why many existing programmes only have a limited impact is that they do not address the broader community/social norms that underlie male behaviour and other gender and HIV-related vulnerabilities and inequities.

GROUP EDUCATION

HIV prevention education that is limited to simplistic, fact-based messages about modes of transmission and risk behaviours does not promote change. Men and boys need opportunities to discuss gender and sexuality and how norms and stereotypes influence their own attitudes and decision-making. Prevention options, including condom use, should be presented as part of a broader discussion in which men and boys critically weigh the costs and benefits of various behaviours and decide for themselves what is most realistic and appropriate in relation to their values and lifestyle. Additionally, men and boys need accurate SRH information and the necessary skills in order to apply this knowledge.

Although it is not necessary to overwhelm men and boys with technical details, education programmes should provide a basic understanding of transmission, how to prevent HIV, testing, disease progression, living with HIV, and addressing stigma and discrimination. Many men and boys lack practical information about HIV

prevention and even basic sexual education. Common areas that need to be addressed include the “window period” for HIV testing and the difference between HIV and AIDS.

Many men also express misconceptions and doubts about condoms, including their efficacy against HIV and the impact on sexual pleasure. Education programmes should provide information about correct and consistent condom use, how to negotiate with partners, and how and where to access condoms and health services. This information should be linked to skills-based lessons—for example, practicing putting condoms on a model of a penis, and speak with a partner about condom use.

When discussing the relationship between condom use and negotiation and gender-equity, programmes might want to introduce the female condom. The female condom, like its male counterpart, is a barrier device used to prevent unintended pregnancy, HIV and other STIs. The female condom is the only

female-initiated technology currently available that enables women to protect themselves, though it is still unfamiliar to many women and men. Nevertheless, it should be promoted as a prevention method, and can be used to explore male ideas about female sexuality, and the role of female-initiated methods. UNFPA advocates comprehensive condom programming, which includes the promotion of male and female condoms alongside communicating for behavioural change, market research, segmentation of messages to different target audiences and the optimized use of reproductive health and HIV/AIDS clinics. This last point is designed to promote prevention, advocacy and the coordinated management of supplies.²³

Information about the link between substance use and HIV vulnerability is also important for men to know. Worldwide, men account for approximately four-fifths of people who use injecting drugs, and studies have shown that male users are also more likely to share needles and avoid using condoms (Lindblad, 2003). Males also use other substances at higher rates than females. For many men and boys, for example, using alcohol or another substance helps them prove their manhood or fit in with a male peer group. It is important that men and boys have the opportunity develop harm-reduction skills

and to deconstruct the pressures which may lead them to use drugs and alcohol.

Finally, education programmes should also offer men an opportunity to reflect on their involvement in care giving. As mentioned before, men (and society in general) often believe that care giving is an exclusively female task. This means that it is women and girls who bear a disproportionate burden of taking care of ailing family members—especially with regards to HIV. **It is not enough that programmes emphasize the need for men to assist in caring and supporting family-members (especially when they are ill) but also to create opportunities for men to learn the skills necessary—from active listening and providing basic medical attention to cooking and cleaning.** The Faraja AIDS Orphans and Training Centre in Tanzania has been encouraging men to become involved in Home Based Care (HBC) since the late 1990s and have found that the involvement of community leaders is vital. Local leaders have an important role to play in identifying appropriate male volunteers and breaking down stigma around HIV/AIDS and home care work. The Centre has also found that mobilizing male volunteers has a positive impact on the community by spurring men to become involved in other AIDS related activities (CPHA, 2005/2006).



²³ For more information on comprehensive condom programming visit UNFPA at <http://www.unfpa.org/hiv/programming.htm>

CASE STUDY 1

POSITIVE MEN'S UNION (POMU) / UGANDA

(PROGRAM TYPE: GENDER SENSITIVE)

Originally founded as a support group by eight HIV-positive men in 1993, the Positive Men's Union (POMU) encourages members to become involved in prevention efforts and provide care for themselves, their families and communities. Chapters throughout Uganda carry out a range of activities including support groups, awareness-building, income generation, support and long-term planning for affected families and collaborative meetings with women's organizations to discuss HIV/AIDS-related gender issues.

As in many other settings, most Ugandan men are still not open about their HIV status—and often do

not even inform their spouses and children. This can be attributed in large part to a reluctance to be seen as weak or sick or needing support. POMU members recognize the importance of men talking to other men and, for this purpose, organize to raise awareness about testing and establish support groups for HIV positive men to share experiences. In these groups, men often want to discuss broader issues such as unemployment and poverty, but their participation has also led to an increase in health-seeking behaviour and improved communication with their partners. (Barker and Ricardo, 2005)

CASE STUDY 2

MEN AS CAREGIVERS IN ZIMBABWE

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

Padare, an NGO in Zimbabwe, carries out community-based trainings to engage young and adult men on the need to share with women and girls the responsibility of caring for family members of others living with AIDS. The trainings are developed after consultations with the target groups of men and focus on empowering them to take on care-giving roles and responsibilities in their communities. Padare encourages men to challenge

the myths and socio-cultural norms that reinforce the division of care-giving in the home and community settings. At the end of the training, the participants are provided with kits with gloves and other materials to enable them to be home-based caregivers. (Shumbu and Eghtessadi nd)

FOR MORE INFORMATION: www.padare.org.zw



HEALTH AND SOCIAL SERVICES

Services that aim to engage men and boys in HIV prevention should take a holistic approach to their health and development. Often, health services that do target men and boys only distribute condoms or provide STI testing and treatment. It is vital that health professionals and services address HIV prevention within a broader understanding of the other health risks that men and boys face—from violence to substance use—and how these risks are also grounded in many of the same rigid gender norms that make men and their partners vulnerable to HIV. Moreover, services should encourage men to be more caring, equitable and involved partners and provide clients the opportunity to develop specific communication and negotiation skills—from how to help a partner decide on a contraceptive method to how to talk to a partner about getting tested for STIs including HIV.

Voluntary counselling and testing (VCT) is a key aspect of effective HIV prevention efforts. When men and boys know their HIV sero-status, they can choose to disclose it and take the necessary measures to protect themselves and their partners, be it from infection or, in cases where men and/or their partner(s) are already HIV positive, from re-infection with another strain. Unfortunately, while routine gynaecological and family planning care—

including pre-natal services—provide a common entry-point for VCT services for women, there are generally no comparable entry-points for men except perhaps couple testing. Therefore, it is important that services seek to identify and make the most of what opportunities there are for engaging men in VCT services—from routine physical exams to condom distribution schemes. Staff at VCT services should always have referrals on-hand for treatment and support. It is necessary to remember, however, that treatment may not be readily available or accessible in many settings and the promotion and provision of testing might lead to various ethical considerations in terms of follow-up services.

Also, depending on local guidelines and laws, parental permission might be necessary to administer the HIV test to a boy under the age of 18, or the legal adult age in country. In some countries, policies are flexible enough to allow so-called "mature minors" to decide for themselves and get tested. The term can refer to those younger than 18 years who are married, pregnant, parents, engaged in behaviour that puts them at risk, or in other relevant situations (such as orphaned and head of a household). If parental consent is required, offer to talk to the parents or guardian (Fisher & Foreit, 2005).

Many men who do test positive for HIV may be reluctant to accept the positive result and to seek treatment. They may feel that accepting and divulging their HIV status to others will make them seem weak or that it will affect their status in their community and their potential to earn money and be employed. As such, part of working with men should help them explore the gender norms, which often contribute to such fears—especially those which imply that men shouldn't be concerned with their health and that to do so is a sign of unmanliness.

For men with partners, services should seek to promote couple counselling, particularly as part of a broader

strategy for PMTCT, also known as PPTCT (Prevention of Parent To Child Transmission) (Greene et al., 2006). Research has shown that male partners can make a real difference when it comes to improving women's uptake of PMTCT services. Research has found that successful outreach efforts have the knock-off effect of making men far more likely to support women in their decision to be tested for HIV, treated with antiretroviral drugs and to practice safer infant feeding methods (Horizons Report, 2003). See Box 5 in the Maternal, Newborn and Child Health chapter for a discussion on involving men in PMTCT.

BOX 3 **MALE CIRCUMCISION AND HIV PREVENTION**

In 2005 and 2006, three randomized trials undertaken in South Africa, Kenya and Uganda found that circumcision reduced the risk of HIV infection among men by up to 60 per cent (Auvert et al., 2006; Bailey et al., 2007; Gray et al., 2007). Based on this evidence, male circumcision (MC) is now recognised as an additional intervention to reduce the risk of heterosexually acquired HIV infection in men, specifically in countries with high HIV prevalence and low prevalence of circumcision. Still, it should be noted that the preventive effect for women has yet to be proven.

Male circumcision should not be seen as an "immunization-type" intervention or a one-time or stand-alone HIV intervention. Rather, MC should be offered in a culturally-appropriate and human rights-based way and as part of

a comprehensive, package that includes HIV testing and counselling services; STI treatment; safer sex practices; the provision of male and female condoms and promotion of their correct and consistent use.

Most current MC education and service efforts target adolescent and young men. Because this population traditionally has very little contact with health services, the provision of MC can serve as strategic entry-point for SRH information and services as well as discussions of gender and sexuality issues related to SRH and HIV and AIDS²⁴. The fact that MC is often provided outside the formal health sector in traditional rites-of-passage ceremonies can present both specific opportunities and challenges.

CAMPAIGNS AND COMMUNITY MOBILIZATION

Campaigns and community-oriented activities related to HIV prevention should address the links between gender, sexuality, and the various risk behaviours and situations which involve men and boys, including multiple concurrent partnerships, cross-generational sex, transactional sex, and drug and alcohol abuse. Campaigns should employ social marketing strategies (see Box 10 in Introduction) to promote more equitable gender relations and specific prevention behaviours such as correct and consistent condom use and the importance of communicating with one's partners.

In terms of mobilizing men to become involved in care and support activities, an important first step is to help them recognize and address their own health needs. Men who are concerned with their own health are more likely to feel the same way about women, children and other men (Peacock, 2003).

Campaigns that portray men attending VCT centres and taking care of themselves (see Case Study 4, for example) can help to counter norms that characterize such behaviour as "un-masculine". In addition to care giving and prevention, HIV campaigns and community mobilization should also address GBV and SRH because of their relationship to the transmission of HIV.

CASE STUDY 3

THE HORA H CAMPAIGN, BRAZIL

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

In the mid-1980's condom social marketing emerged as a popular HIV prevention strategy (UNAIDS, 2000). A number of condom social marketing programmes have raised general awareness of HIV transmission and prevention, increasing sales of marketed condom brands as well as affecting attitude change towards condom use in targeted groups, including young men (Horizons, 2003; JHUCCP, 1997; UNAIDS, 2000).

One example of condom social marketing is the Hora H campaign developed in Brazil by Promundo and John Snow, with financial support from SSL International. Roughly translated as, "in the heat of the moment" the campaign builds upon social marketing principles to promote an attractive and more gender-equitable lifestyle for young men.

The Hora H Campaign includes an associated condom brand; although the campaign promotes condom use as an important behaviour in and of itself, the main emphasis is on the lifestyle, which is symbolized by condom use. Campaign messages describe a "real" man as one who demonstrates more gender-equitable attitudes in his relationships, particularly in the more challenging moments. The link between the Hora H condom, a "product", and a lifestyle draws from principles of commercial marketing in which advertisements for cars, shoes and other products focus on the lifestyle associated with ownership of the product, rather than the qualities of the product itself. In the case of Hora H, this strategy is used to market healthy and equitable behaviours, such as condom use, as part of a cool and hip lifestyle for young men.

FOR MORE INFORMATION: WWW.PROMUNDO.ORG.BR

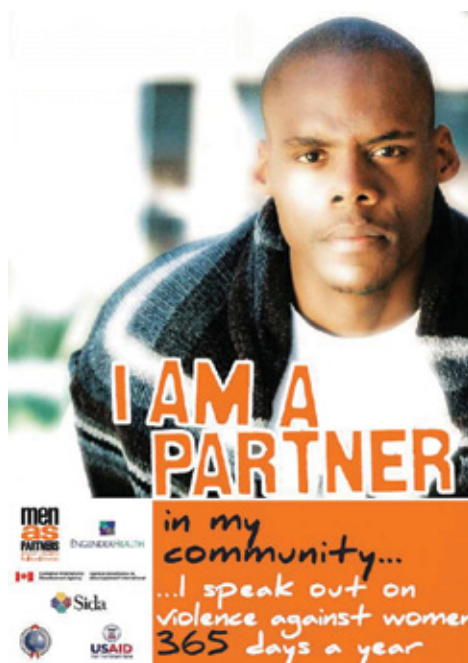
CASE STUDY 4

I AM A PARTNER, SOUTH AFRICA

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

In 2007, Engender Health South Africa's Men as Partners (MAP) Programme launched an "I am a partner" media campaign. The campaign was designed to help men understand what it means to be a true partner within the context of relationships, families, and communities. One specific theme of the campaign has been mobilizing men to get tested for HIV with the message "I am a partner—I am not afraid to test". Campaign sponsors hosted a testing day for all men, including some popular South African celebrities to show their commitment to women by getting tested for HIV, and purchased a mobile testing unit.

FOR MORE INFORMATION: WWW.ENGENDERHEALTH.ORG



TOOLS

Services: Developing a Fact Sheet About Men and Boys and HIV Prevention

Services: Tips for Providing VCT

Education: Living Positively – Digital Stories

Education: Getting Tested for HIV

Gender-Based Violence



Gender-based Violence (GBV) is now widely recognized as an international public health and human rights concern. According to the UN Declaration on the Elimination of Violence Against Women, the term 'Violence Against Women' means any act of GBV that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

The concept of GBV seeks to distinguish violence that is based on gendered expectations and or on the sex or gender identity of another person from other types of violence. GBV generally seeks to reinforce traditional gender roles and inequalities through physical, sexual and psychological abuse: "GBV can apply to women and men, girls and boys (UNFPA, n.d.)." That said, even though violence against boys and men is of grave concern, "the UNFPA focus (and that of this toolkit) remains on tackling violence against women and girls, since it is they who are overwhelmingly affected (UNFPA, 2008)."

The World Health Organization (WHO) multi-country study provides one of the most robust sources of information on the extent of male violence against women as reported by the women themselves (García-Moreno et al., 2005). The study found that the percentage of women who reported physical or sexual violence by a partner ranged from 15 to 71 per cent, with the majority of countries falling between 29 and 62 per cent. Although the main focus of the study was intimate partner violence, it is important to recognize that there are many other forms of GBV – from sexual harassment in the workplace to honour killings by families. All of these reflect and reinforce gender and power inequalities between men and women through the use of violence.

In the past two decades women's rights advocates, governments and UN organizations have devoted most of their attention and resources to protecting and providing support for women and girls affected by various forms of GBV. There has been significantly less attention to working with men and boys to prevent

BOX 1

WHAT ARE THE DIFFERENT TYPES OF VIOLENCE?

Physical violence: Using physical force such as hitting, slapping, or pushing.

Emotional/psychological violence: Often the most difficult form of violence to identify. It may include humiliating, threatening, insulting, pressuring, and expressing jealousy or possessiveness (e.g., by controlling decisions and activities).

Sexual violence: pressuring or forcing someone to perform sexual acts (from kissing to sex) against their will, or making sexual comments that make someone feel humiliated or uncomfortable. It does not matter if there has been prior consenting sexual behaviour.

Economic Violence: involves exerting control over household resources and blackmailing or threatening to withhold resources from a partner.

such violence in the first place. The growing consensus, however, is that men and boys have an essential role to play in ending violence, both within their own relationships as well as in their larger communities. There is also now an increased recognition that men's violence against women is deeply rooted in rigid gender norms and the manner in which boys and men are socialized.

Men and boys are often socialized to repress their emotions and anger is sometimes one of the few socially acceptable ways for them to express their feelings. Some men and boys are also raised to believe that they have the "right" to expect certain things from women, and the right to use physical or verbal abuse as a form of "punishment" if women do not provide these things (responding to sexual demands, for example). Sexual violence in particular is also rooted in non-equitable gender norms—especially those that define male sexuality as uncontrollable and aggressive and female sexuality as passive.

Research has confirmed that violence is mainly a learned behaviour (Bandura, 1965; Cunningham et al., 1998). Boys who are raised to believe that violence against women is "normal" may be more likely to repeat this violence in their own intimate relationships. In one large-scale study in the United States, for example, men who had witnessed violence against women as children were three times more likely to use domestic violence as adults (Straus, 1990; Straus et al., 1980). Qualitative research in Brazil found that many young men who reported witnessing violence in their homes,

felt powerless to speak out against this violence and also feared that if they intervened, the violence would be directed toward them (Barker, 2001).

Overcoming the silence of men who witness other men being violent toward women is a key starting point for this work. At the same time, it is important to emphasize that men who witness violence during their childhood do not inevitably become violent—indeed, research and programme experiences have shown that such men are capable of reflecting on the costs of what they witnessed and making a deliberate choice to practice non-violence in their own lives.

In addition to family and role models, men and boys also learn to be violent from the community and culture around them. Since the media and community reflect the predominant culture, consideration should be given to the challenges that culture and social norms present to working with GBV. Some traditional norms or cultural traditions can at times facilitate GBV or make it difficult for the woman to react or leave situations of violence. Some traditions that support GBV include bride price, the widespread belief that "between a man and a woman no one should interfere", and less common beliefs such as the belief that murdering a woman redresses family 'dishonour'—i.e. honour killings. Engaging the community to critically reflect on negative norms and practices (while keeping in mind the positive values within a culture) and the impact of violence on women's rights is therefore a fundamental part of working to prevent GBV.

BOX 2

VIOLENCE BETWEEN MEN

The violence that occurs between men is often linked to rigid gender norms and power dynamics. Boys and men may be taught, for example, that violence against others is an acceptable means of demonstrating strength and control or that to avoid being victims they must perpetrate violence towards others.

The use of violence against other men can be, among other things, a way to achieve a socially recognized status as a man when other forms of recognition or affirmation are unattainable or perceived to be unattainable. In this way, violence may serve as a mechanism by which some men and boys are placed or kept in a position subordinate to other men. The most extreme form of this violence is homicide. WHO estimates that 80 per cent of homicide victims are males, and that men are three to six times more likely than women to commit murder.

Male-to-male violence can also be linked to gender norms that underlie violence against women and girls. Violence can act as a means of censorship and form of control over male behaviour. It can be used against men who do not adhere to rigid gender scripts and norms, the most extreme example being homophobic violence against men who have sex with men (MSM) or those who self-identify themselves as non-heterosexual.

Men who deviate from norms regarding male behaviour, dress, interests, etc, can also find themselves victims of violence or harassment. Indeed, this type of violence is shaped by many of the same negative views of women and femininity that perpetuate male violence against women.

WHY SHOULD MEN BE ENGAGED IN GENDER BASED VIOLENCE PREVENTION?

Men have a fundamental role to play in the prevention of GBV. First of all, men influence men. It is men's support (either explicit or implicit) of negative gender stereotypes and unequal relationships, which help to perpetuate GBV. Because men listen to other men, they will be likely to pay attention to men who question these stereotypes and speak out against violence. Secondly, men are not involved to the same extent as women and women's groups in speaking out actively against GBV. This void makes GBV prevention appear to be a women's issue only and something in which men do not need to or should not participate.

At the same time, however, the participation of men in programmes that address GBV can generate certain levels of scepticism or unease, given the fact that men are generally the perpetrators of violence. It is therefore important that the involvement of men be defined in collaboration with women and women's groups. Moreover, many men may themselves need to be convinced as to why they should participate as well as be persuaded of their ability to bring about change. Men and boys need to be taught that they have an important stake in ending GBV and in showing the world that the majority of men are not, and do not support violence, and that they are willing to speak out against it. They need to understand how their involvement in ending GBV benefits themselves, their partners, their daughters, the lives of other women and girls they know and care for—as well as the larger community and society as a whole.

In working with men to address GBV, it is paramount that men be seen as part of the solution as well as part of the problem. Programme approaches, campaign messages and images that vilify and stereotype men as aggressors, for example, will do little to positively engage them. As Kaufman stresses, "language that leaves men feeling blamed for things they have not done or for things they were taught to do...will alienate men and boys" (Kaufman, 2004). Indeed, a study conducted by the US-based Family Violence Prevention Fund found that 13 per cent of 1,000 men interviewed expressed a reluctance to become involved in violence prevention activities because of their perception that men were often vilified through such activities (Garin, 2000).

MEN AND GBV IN POST CONFLICT SETTINGS

Throughout the history of conflict, GBV—including rape, sexual, physical and psychological assault—has been used as a weapon of war to destabilize populations, disrupt social cohesion and transform the ethnic and social composition of warring groups²⁴. Unfortunately, GBV does not end once civil conflicts are resolved. The existence of factors that perpetuate continued GBV include increased tolerance to the use of violence, inadequate (and at times, non-functional legal systems) that perpetuate impunity for perpetrators, the adoption of violent role models or identities during conflict, and the effects of trauma on individuals and families. Other factors include extreme poverty that result from economic disruption and displacement, as well as the destruction of social networks and support mechanisms. Amidst these multiple and interdependent factors, however, it is important to recognize how concepts of gender and masculinity perpetrated by men during and after conflict may also contribute to violence.

Male violence may be an outcome of norms promoted by societies and reinforced by states that link masculinity with militarization, and that manipulate gender role expectations for political gain.

Additionally, shifts in gender roles that emerge post conflict may trigger violence by men against women. For example, women may be targeted as beneficiaries for health and development programmes, resulting in changes in their productive and reproductive roles and responsibilities. These changes can cause resentment among men who hold rigid notions about what it means to be male and female and thus can contribute to family violence.

An important paradigm shift around how to address GBV in post-conflict settings has occurred in the last decade. Initially, the humanitarian response to sexual violence affecting women emphasized the provision of treatment services within a reproductive health context. Now, there is increased recognition that programming must be multi-sectoral—the result of coordinated activities between affected communities, health and social services, and the legal and security sectors in the context of humanitarian assistance, disarmament, demobilization and reintegration and reconstruction (DDRR). Moreover, multi-sectoral programming must be based on sound gender analysis and mainstreaming that takes into account gender roles and responsibilities: One that includes transformative

²⁴ It is important to note that while women and girls are victimized in much greater numbers, either through rape, sexual slavery, trafficking and forced pregnancies, men and boys are also victims of sexual violence during and after conflict. According to the 2005 Human Security Report, cases of sexual violence against men and boys involved in armed conflict or displaced by it have been documented in the majority of the 59 conflicts occurring in the last 10 years. Such violence aims to destroy male power by humiliating and emasculating men, and can have profound effects on men's psychological well-being.

approaches that create more gender-equitable roles and relationships.

There is a small, but growing number of efforts to engage men in GBV prevention and mitigation in post-conflict settings. At the community level, Care Burundi has created “Abatangamuco”²⁵, (“give light to darkness”) which uses dialogue and debate about gender roles to mobilize men to make a personal commitment to changing their behaviour toward women. In Cote d'Ivoire, the International Rescue Committee (IRC) is evaluating whether participation in men's groups leads to changes in gender roles, relationships and their use of intimate partner violence. The IRC is also providing psychosocial support and counseling in the Democratic Republic of Congo (DRC) to family members—particularly husbands—to prevent men from divorcing or beating wives who have experienced rape. In the DRC, Women for Women International

has piloted the Men's Leadership Programme, which educates and enhances the capacity of community and traditional leaders to address violence against women.

International and national aid agencies and NGOs are also undertaking critical work with the uniformed services that builds on several Security Council Resolutions—including most recently, 1820—which calls on UN agencies to develop mechanisms to protect women and girls from sexual violence. UNFPA has taken the lead in Sudan and DRC to implement such innovations. Interventions include arranging men to act as escorts for internally displaced women and girls as they collect firewood, and training and supporting special police protection units for women and children. Similarly, Engender Health partners with the South Africa, Ethiopia and Tanzania Defense Forces, and the Namibia Police and Prison Guards.



²⁵ <http://gender.care2share.wikispaces.net/CARE+Burundi>

PROGRAMMING TO ENGAGE MEN AND BOYS IN GBV PREVENTION

Engaging men and boys to prevent GBV is fundamental to the achievement of gender equality. Because men are overwhelmingly the main perpetrators of violence against women, it is logical that they be key partners in the struggle to end it. Programmes which focus on treating perpetrators of intimate partner violence, are also required—although these are complex and not available in many countries (See Box 4). Moreover, while work with perpetrators is important, attention and resources should be primarily focused on the needs and risks of survivors of violence. This means establishing referral networks and strengthening counselling, legal and health services.

GROUP EDUCATION

Some men believe that violence can solve their relationship problems or may resort to it out of exasperation or perceived lack of alternatives. Education programmes offer men and boys an opportunity to discuss and question the norms and inequities that underlie the use of violence against women and help them develop the skills necessary to handle conflict in non-violent ways and to engage other men to do the same. Programmes should improve participant understanding of the causes and consequences of violence against women and also provide basic knowledge about HIV prevention, treatment, care and support, sexual and reproductive health (SRH), maternal, newborn and child health (MNCH), alcohol and drug abuse, men's mental health, and other relevant issues linked to GBV. In terms of sexual violence, men and boys need to understand what is, and is not, sexual consent.

Skills-building activities should include, for example how to express feelings without becoming violent.

And how to manage anger and resolve conflicts in the context of couple relationships. Programmes should seek to help perpetrators to recognize what triggers their violent reactions and how to prevent these trigger situations from escalating into violence.

It is important that programmes encourage men to take responsibility for their own actions and to provide alternative models of positive behaviour and examples of ways in which men can intervene to prevent violence among their friends, neighbours and communities.

Encouraging men to reflect on the violence they may have suffered from, or perpetrated against other men, can help them to become more empathetic to the violence that women and girls suffer. This empathy can, in turn, enable them to challenge other men about violent attitudes and behaviour — including GBV — and to become role non-violent masculine role models.

BOX 3

ETHICAL CONCERNS IN WORKING ON GENDER BASED VIOLENCE

It is of the utmost importance that educators, services providers and others working on GBV are clearly aware of their responsibilities and legal obligations with regard to reporting requirements and testifying at trials. As part of their work, they may be confronted with situations in which an individual tells of an actual, suspected or past

abuse suffered, witnessed, or perpetrated. Those working with these individuals should be cognizant of their legal responsibilities with regards to reporting and also be equipped to refer individuals to relevant counselling programmes or other services.

Many examples of initiatives that work with male perpetrators of GBV come from countries in Europe and North America. Increasingly however, other countries—especially in Latin America—are launching their own initiatives. In Brazil, for example, the 2006 federal law regarding violence against women (also known as the Maria da Penha Law) provided for the creation of “rehabilitation and education centres for men committing acts of violence”.

In March 2009, a rehabilitation centre for men who have used violence against women was inaugurated in the state of Rio de Janeiro with support from the Special Secretariat for Women's Policies. The sentence for many men convicted of using violence now includes mandatory attendance of 20 group therapy sessions at the centre. The goal of these sessions, which are held over a period of five months, is to help perpetrators to reflect on their behaviour and develop communication skills as a substitute for violence. More than 100 men have participated in the sessions to date and the government plans to extend the project to 78 municipalities.

Such programmes are often referred to as “batterer intervention programmes” or BIPs. As with the Brazilian example cited above, the majority of these are linked to the legal system and work with men who have been tried and convicted and are obligated to attend either to defer sentencing or as a condition of their release from prison. The underlying premise of BIPs should be that violence is a learned behaviour that can be unlearned.

Sessions should engage men in reflections on the underlying motivations and consequences of their behaviour as well as a questioning of prevailing gender norms that allow them to think that men should have more power or control in an intimate relationship. Although it is common for participants to initially deny their guilt, many are able to assume responsibility after sufficient time and reflection. Defining what constitutes a sufficient “dose”, however, is still an issue for debate. There are

still questions regarding the necessary number of group sessions as well as to whether group counselling may have a stronger impact if accompanied by individual therapy. One thing that is clear is that the quality of counsellors and group facilitators make all the difference and should receive intensive training as well as on-going support.

Although the evaluation of such programmes has been rather limited, existing data indicates that BIPs range from moderately- to highly-successful with regards to preventing future violence: A number of programmes have reported up to an 80 per cent reduction in GBV. It is also clear, however, that some men do not change their behaviour even after attending a BIP (Bennett and Williams, 2001, Gondolf, 2002, Saunders, 1996).

BIPs can often be controversial and greater attention needs to be paid to their implementation as well as evaluation and follow-up with participants and their partners. Some women may base their decision on whether to stay with a partner on his participation, which means their safety and well-being is in many ways dependent on the “success” of the programme.

BIPs should use partner reports to evaluate the impact of their work since self-reporting by perpetrators is often subject to denial and/or minimization. It is also important that BIPs not be undertaken in isolation: They should be linked with other services that meet the support and safety needs of the women and children affected by the perpetrator's actions.

Existing BIP models and programmes combine different approaches. Nevertheless, whichever approach is chosen, programmes working with perpetrators of violence against women should be based on a critical analysis of prevailing gender norms and a thorough examination of GBV as a manifestation of a disparity in power. The goal should be to overturn gender stereotypes that legitimize GBV.

SERVICES

Most of the services-related work on violence is focused on women as the primary victims. Indeed, women are more likely to approach health care providers with domestic violence concerns than anyone else—One US study found that up to 37 per cent of all domestic violence survivors spoke to their health provider first. (Family Violence Prevention Fund, n.d.)

Women who suffer violence also often end up accessing services to treat their injuries, although they may not necessarily always identify themselves as victims of violence. Providers should therefore be trained to screen for violence and to provide necessary care and assistance when it has been identified—including where to refer victims, how to document evidence of assault, and where to access available legal recourse. Male service providers, in particular, represent an important target group for sensitization efforts. In many settings, they constitute the majority of service providers and therefore represent the frontline when it comes to identifying and responding to men's violence against women and girls.

At the same time, SRH services also provide an entry point for identifying women and girls who have been

abused. This is especially the case at the first point of contact: A woman's visit to a reproductive health service provider may be her only chance to escape an abusive situation and receive care and support. Most women, even those living in marginalized and remote areas are likely to seek family planning or prenatal care services at least once in a lifetime. This makes reproductive health services a critical entry point for violence-related information and services (UNFPA Strategic Framework for Action to Addressing Gender Based Violence, 2008-2011).

Likewise, service providers should ask male clients about the quality of their relationships and stress level during routine health screenings. Men who report experiencing stress in their relationships or express frustration with their partner should be referred to counselling. Men who report having used or continuing to use violence in a relationship need to be referred to services targeting aggressors, if they are available, and if not, to regular counselling. In countries where neither of these are available, service providers should familiarize themselves with NGOs and/or projects which work on GBV and to which these men could be referred to for additional information or an opportunity to talk about the issue.

CAMPAIGNS AND COMMUNITY MOBILIZATION

Effective and promising campaigns focusing on GBV prevention overwhelmingly use positive and affirmative messages. They affirm that men and boys can change, show what they can do to change, and feature examples of men altering their behaviour or behaving in positive ways (whether they be characters in theatre, television shows, radio dramas or print materials). Many of the most successful campaigns demonstrate how men and boys personally gain from changing harmful behaviour.

Many effective campaigns and community outreach interventions identify groups of men or individual men who influence the behaviour of other men. These include coaches, fathers and professors. As well as custodians of cultural norms such as village and community elders, religious leaders, traditional opinion leaders and "holders" of customary law who have a massive and influential reach. It is essential that these men already support non-violent, gender equitable and caring attitudes and behaviour.



BOX 5

POLICE AS PARTNERS IN ENDING GENDER BASED VIOLENCE

As a predominantly male institution and one that is largely responsible for enforcing laws that protect women from violence, the police are an important target for sensitization, training, and advocacy efforts. They need to understand the causes and consequences of violence against women as well as the legal mechanisms to address it. Many advocates have dedicated themselves to urging police to intervene in cases of domestic violence.

Some studies (Sherman and Berk, 1984) have shown that arrest is a deterrent to domestic violence and can prevent continuing violence. Arrest alone, however, is often not a sufficient response to situations of violence and indeed, can often lead to further consequences. That being the case, arrests and legal recompense must be part of a larger comprehensive approach, which includes safe houses and support services for women as well as counselling and rehabilitation for the men.

Founded in 1998, Rozan is an NGO based in Islamabad, Pakistan that seeks to protect the emotional health of women and children. Rozan's specific activities include

advocacy, direct services, training and education. Although most of the NGO's work has been aimed at women and children, personnel also recognize the importance of working with men.

The organization has developed and implemented of a curriculum for police, which promotes gender sensitization and communication skills. The curriculum is a part of the Police Academy's training curriculum and encourages trainees to reflect on how their attitudes and behaviours can contribute to further victimization of those who experience violence and seek help. Police trainees also develop skills that are critical for their own work, for example, how to: manage anger and curb violent reactions; manage stress and care for oneself; negotiate situations of power and control in an assertive, non-violent manner, and how to communicate from a position of strength. Evaluations have shown that the curriculum has increased police sensitivity to, and awareness of, violence against women.

FOR MORE INFORMATION: WWW.ROZAN.ORG.

CASE STUDY 1

MEN'S ACTION FOR STOPPING VIOLENCE AGAINST WOMEN (MASVAW), INDIA

(PROGRAM TYPE: GENDER SENSITIVE)

Men's Action for Stopping Violence Against Women, or MASVAW, is a network of over 175 individuals and 100 organizations working in the Indian States of Uttar Pradesh and Uttaranchal. The network's aim is to increase public awareness of the extent of violence against women in India and to motivate men to take a public stand against the problem. Some MASVAW activities include: organizing workshops in universities; training and supporting journalists to address violence against women in the media; coordinating rallies and demonstrations at the grassroots level, and sensitizing various service providers.

In a few villages in Uttar Pradesh, MASVAW is also working with boys and girls aged between 8-12 years using drama and games to introduce the issue of violence against women (see Tool—Snake and Ladder game, for example). MASVAW groups are now active

in 40 districts of Uttar Pradesh and three districts in the neighbouring state of Uttaranchal. The are plans to replicate the campaign in different Indian states and to establish a national coalition.

FOR MORE INFORMATION: MASVAW@SAHAYOGINDIA.ORG



CASE STUDY 2

THE WHITE RIBBON CAMPAIGN

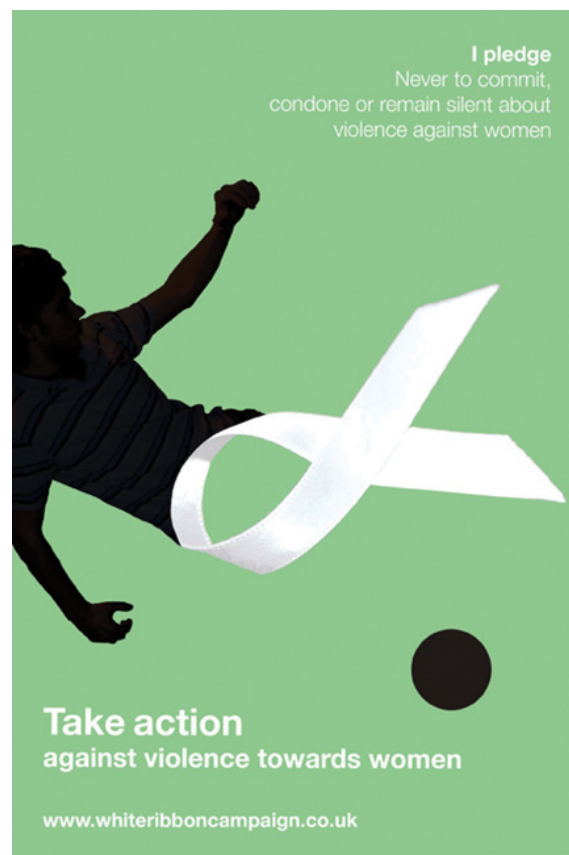
(PROGRAM TYPE: GENDER TRANSFORMATIVE)

The White Ribbon Campaign (WRC) is the world's largest effort involving men working to end violence against women. Started in Canada in 1991 after the massacre of 14 female students at Montreal's L'ecole Polytechnique, WRC is now present in over 55 countries and is led by both men and women—even though the focus is on educating boys and men.

Moreover, while the ribbon originated as a symbol of men's opposition to violence against women, in many schools and communities worldwide it is everyone who wears it. For men and boys: The ribbon represents a personal pledge to, "never commit, condone or remain silent about violence against women and girls". For women and girls: the ribbon is a show of recognition that men and boys have a role and responsibility to end violence against women.

WRC has also produced educational materials to assist teachers and community leaders to raise awareness and build skills among youth (boys and girls) regarding healthy and equal relationships. These have been used in more than 3,000 schools across North America and have been found to positively influence attitudes, knowledge, and behaviours related to violence against women.

For more information: www.whiteribbon.ca



CASE STUDY 3

COACHING BOYS INTO MEN, USA

(PROGRAM TYPE: GENDER TRANSFORMATIVE)

Led by Family Violence Prevention Fund (FVPF) Coaching Boys into Men is a national multi-media campaign that builds on a sport motif to encourage men to be positive role models for boys and young men and teach them about healthy and respectful relationships. In addition to efforts to engage fathers and other men, FVPF has also partnered with the National High School Athletic

Coaches Association to involve coaches in the campaign effort. This has included the creation of materials to help coaches incorporate messages and discussions about violence against women in the locker room and on the field.

FOR MORE INFORMATION: WWW.COACHES-CORNER.ORG.

TOOLS

Education: Don't Stand By, Take Action

Education: What is Violence?

Education: Snake and Ladder Game

Education: Violence against Women in Daily Life

Education: Coaching Boys into Men material

Services: Domestic Violence Assessment Guide

Advocacy And Policy



WHAT IS ADVOCACY?

While engaging men and boys through group education, health services and community mobilization can have a significant impact on their attitudes and behaviours, there is also a need to advocate for changes in the political, legal, cultural and economic structures which shape the lives of women and men and often perpetuate many gender inequities.

Advocacy can be defined as the process of building support and positively influencing decision-making and hence policy on a given issue. It can entail a multitude of approaches and tactics that can be undertaken at various levels: from capacity building and dialoguing with community leaders to garnering political commitment and support for the scaling-up of successful interventions and policies that target men and boys.

Advocacy for gender equality, therefore, includes lobbying for changes in laws or regulations that perpetuate inequality. Advocacy means pushing for legislation that, for example, criminalizes violence against women and grants paternity as well as maternity leave, promotes the presence of men in pre-natal services and the delivery room and guarantees women equal pay and employment opportunities—to name a few.

During the last 15 years, an increasingly positive international climate, as reflected in a series of milestone conferences and meetings, has favoured the engagement of men and boys in health and gender-equality (see Box 1 in the Introduction). Likewise, a growing body of programme experiences and evidence has highlighted myriad strategies for engaging men and boys in Sexual Reproductive Health, Maternal, Newborn and Child Health, fatherhood, HIV/AIDS, and violence prevention. More importantly, this evidence has confirmed that there are real benefits for both male and female health. The emergent research and program experiences around the issue of male involvement can be utilized for advocacy around engaging men and boys.

The strategies and tips presented in this section draw from advocacy experiences related specifically to promoting male involvement in health and development agendas. Specific topics include engaging community stakeholders, media and government and building alliances.

CREATING AN ADVOCACY STRATEGY

The first step to creating an advocacy strategy designed to engage men and boys is to carry out a needs-assessment about how gender norms influence male attitudes and behaviours—and the opportunities, programmes and services needed to effectively involve them.

This assessment should be followed by another needs assessment to determine what types of advocacy have already been undertaken or are underway—not only with respect to engaging men and boys—but also with other related issues such as gender mainstreaming.

The advocating organization should familiarize itself with the political climate in the country and region and the potentials and possibilities as well as drawbacks or consequences of the assumed advocacy strategy. Once the decision has been made to move forward, it will be necessary to train staff in advocacy techniques.

Developing and executing a plan designed to influence legislators and policymakers requires a skill set of its own and needs to be developed among staff tasked with planning and implementing advocacy activities. Still, this should not deter organizations from getting involved in advocacy—especially on issues they understand intimately. Box 1 examines common myths about grassroots advocacy and highlights reasons for organizations to be involved even if they have no previous experience.

When launching an advocacy campaign, it is necessary to identify key stakeholders at different levels, from schools and communities to local and national government, and to develop clear and simple messages for mobilizing them. These messages

should revolve around the benefits of applying a gender lens—including how socialization and gender norms shape male attitudes and behaviours and put both themselves, and women and girls, at risk. It is especially critical to argue what men and boys will stand to gain and what they stand to lose if they do not get involved. Messages need to be tailored to specific stakeholders and their standpoints.

As will be discussed in the next section, it is particularly important to be aware of the resistance and concern stakeholders may express in relation to working with men and to be prepared to address them. For example, some women's rights groups often want to know how male involvement will directly benefit women, and want to be assured that it will not detract from funding or support for women's issues. Likewise, governments and donors often want to know how working with men and boys will contribute to broader social and development issues. Other groups may directly oppose your work. The tools section includes an activity for dealing with such groups (Tool: Dealing with the Opposition).

BOX 1

MYTHS ABOUT GRASSROOTS ADVOCACY

MYTH #1: Grassroots advocates must fully follow and understand the details of complex legislative processes in order to be effective.

MYTH #2: It takes hundreds or thousands of people taking action in order to get a legislator's attention.

REALITY #1: You don't have to be an expert. In fact, while it's helpful to understand the basic steps that policymaking follows, good grassroots advocates shouldn't try to become professional lobbyists. You can still build an effective grassroots operation, because you know everything you need to know:

- You know the elected officials who work for you.
- You know your story.

- You know the issue and your position on it.
- Grassroots advocacy is all about sharing those basic points with the people who represent you.

REALITY #2: Collective action by even five people can get the attention of elected officials, depending on the timing, context, and nature of the contact. The truth is that government officials don't often hear directly from their constituents, so if you generate a few personal contacts that are effectively planned and if you maintain those contacts, you will set yourself, your views, and your cause apart.

TAKEN FROM THE GLOBAL AIDS ALLIANCE'S ACTIVIST TOOLKIT AVAILABLE AT: [HTTP://WWW.GLOBALAIDSALLIANCE.ORG/ACTION/SHARPEN_YOUR_SKILLS/](http://www.globalaidsalliance.org/action/sharpen_your_skills/)

ADDRESSING COMMON CONCERNS

Although there has been increasing recognition and evidence regarding the importance of involving men and boys in the promotion of health and gender-equity, there is still some resistance to the idea. Some of this comes from donors who have no prior experience working with men; women's groups who fear that resources are being shifted from the very pressing needs of girls and women; and NGOs and other providers who believe men are difficult to work with (Rivers and Aggleton, 2002). Some of the most common concerns and reservations related to working with men and boys are described below. It is important to be aware of these and to be prepared to address them.

WHY SHOULD MEN CHANGE?

A common rebuttal to work with men and boys is that it is futile to expect men to change their attitudes and behaviours because they are the ones who benefit from gender inequality. However, as has been discussed throughout this toolkit, rigid gender norms also leave men and boys vulnerable to various health problems. Moreover, other factors, from ethnicity to socio-economic class, may interact with gender and aspects of masculine identity to further increase vulnerability. Advocacy strategies should therefore call attention to the "double-edged nature" of gender stereotypes—that is, the fact that benefits and privileges bestowed upon men in patriarchal and sexist societies also come at a cost and even

more so for certain groups of men. This should be used as leverage to promote awareness of why it is necessary to change and what the benefits are of building relationships between men and women based on equality and mutual respect rather than fear and domination (Peacock and Levack, 2004).

It can also be useful to cite the increasing body of evidence that shows that men can, and do change, as a result of well-designed interventions—principally those which incorporate a gender perspective—and that these changes lead to benefits for everyone (Barker et al., 2007).

ADVOCACY AUDIENCE

COMMUNITY STAKEHOLDERS

The process of building support for working with young men begins at the local level. Community stakeholders—from parents and teachers to religious leaders and popular figures—play a prominent role in ensuring that programmes and policies are rooted in, and relevant to, local realities and culture.

These groups speak up for the establishment of positive policies as well as reinforcing the constructive changes in men's attitudes and practices, which are promoted in workshops and campaigns. Stepping Stones—originally developed in Uganda and now adopted in a number of regions—is one example of an intervention model that incorporates community-based advocacy. The intervention consists of a series of educational workshops focusing on young and adult men and women about gender-roles, communication, relationships and HIV prevention. The first step is to engage community leaders and to obtain their support. Leaders then go on to invite other community members to participate in the workshops. **The support and involvement of community leaders lends credibility to the intervention and ultimately strengthens the community's commitment to sustaining change.** Other strategies for engaging community stakeholders are presented below.

It is also important to involve community stakeholders in advocacy actions with media and government, which are described below. Among the most essential community stakeholders are the men and boys themselves. Men and boys can be particularly valuable and persuasive spokespersons when it comes to addressing media and government and mobilizing other men and boys on issues related to gender-equality and health (Ingham and Mayhew, 2006). To this end, they should be provided with ample

opportunities to communicate their ideas and opinions within and outside the community.

Faith-based organisations (FBOs) are also valuable community stakeholders. Even though different interpretations of religions or religious texts are frequently used to support gender inequality, religious leaders and institutions can be an avenue for questioning inequitable attitudes. Owing to their influence and their involvement in social development (FBOs provide 30 to 70 per cent of health services in developing countries), FBOs can help to challenge inequitable interpretations of different religious scripts and can be powerful allies to promote gender equality. Also, because they are mainly male-led institutions (99 per cent of religious leaders are men and 85 per cent of FBOs are led by men), FBOs are a natural partner when it comes to working with men to address traditional male gender norms (UNFPA, 2008).

MEDIA

The mass media is a powerful forum for shaping attitudes and opinions. It can therefore be a strategic vehicle for influencing public opinion with respect to the importance of engaging men and boys in the promotion of gender-equity and health.

Media Advocacy targets decision-makers directly and indirectly by motivating the general public to pressure them. Part of a media strategy can also involve advocating directly with the media itself. This entails building capacity for media specialists (journalists, reporters, etc.) so that they understand the importance of promoting gender-equitable messages and images and the benefits of working with men and boys. It also entails setting up a network of media contacts committed to speaking up about and supporting work with men and boys. It is important

to provide the network with new information about programmes and related studies and to encourage site visits and interviews with direct beneficiaries and programme planners.

Some strategies for working with the media include providing the media with press releases or other relevant materials to support them in developing a story, informing the media about upcoming events, writing editorials in local papers, and holding press conferences.

Examples of how to do some of the above are included in the tools for this section. Information provided to the media should always be packaged in ways that capture the attention and interest of the policy actors and the public. For example, the dissemination of the Program H impact evaluation results in Brazil included headlines in national newspapers such as "Machismo is bad for one's health" and "Macho men are more at risk"(for more information on Program H, see Case Study 1 in the Introduction).

Another media strategy is to identify and endorse "celebrities" such as sports figures and musical artists who can use their charisma and credibility to advocate for the need to work with men and boys for a more gender-equitable society. For example, the White Ribbon Campaign in Brazil recruited four well-known actors to participate in a public service announcement designed to raise awareness of GBV (for more information on the White Ribbon Campaign, see Case Study 2 in the chapter on GBV).

In addition to celebrities, media advocacy efforts should also identify and recruit "everyday" men who can share their stories of how they challenge non-equitable gender stereotypes in their daily lives and relationships. These men can help to mobilize the attention of the general public and reinforce the possibilities for men to make changes in their own lives.

Either way, spokespersons for an advocacy campaign need to be scrutinized to ensure that their personal values and practices are in alignment with the organization and the advocacy campaign in which they are involved.

Also, it is important that spokespersons receive training on working with the media to promote the campaign. This can include developing talking points and going over the details about what the organization is seeking to accomplish and how this also relates to their behaviour and lives.

GOVERNMENT

Worldwide, government policies testify to a lack of attention to the gender-specific needs and realities of men and boys and strategies to involve them

in the promotion of gender equality and health. Many policies that do recognize gender as a variable continue to only focus on women and girls as the way to achieve gender equality. While it is necessary to have specific policies to promote the empowerment of women and girls and their inclusion in programmes and services, the absence of a gender perspective that also involves men and boys can ultimately detract from the effectiveness of policies

As noted earlier, media advocacy and community mobilization are critical to targeting government and policy makers both directly and indirectly. Other approaches, which target government directly, include lobbying and/or face-to face meetings with government representatives, letter writing campaigns to government representatives, and election-based campaigns designed to mobilize votes for candidates who support the issues.

In any advocacy strategy, it is also critical to demonstrate to the government how it will benefit by supporting those policies. For example, one focus of advocacy efforts targeting government can be the collection and analysis of gender-disaggregated data related to health-related behaviours and vulnerabilities. Many governments oversee or participate in large-scale censuses or surveys that collect information on various causes of morbidity and mortality and related behaviour indicators. The gender disaggregation of this information can provide valuable insights for programme planners and advocates on differential behaviours and prevention needs of men and women. It also helps government planners do their job and results in more successfully targeted strategies.

Advocacy efforts with government should also include strategies designed to integrate successful programme strategies into government agendas. To date, most successful interventions with men and boys have been mostly NGO-led, limited in duration and generally only reach several hundred to at most a few thousand. The integration of workshops, campaigns and other activities into government settings such as public schools can help to achieve the large-scale and sustained reach necessary to change existing gender norms and power dynamics related to the health vulnerabilities of men and women.

Other possible topics with which to lobby government and policymakers include paternity leave, policies that support fathers who do not cohabit with the mother, legislation that makes GBV a crime, laws and regulations that support male involvement in maternal health and permit their presence in the delivery room, and supporting SRH education for men and boys. This section includes a tool for lobbying or meeting with decision-makers to discuss issues and influence policy.



GENDER EQUALITY POLICY

Around the world, there exists an enormous variation in gender equality policies and agencies. Even when gender ministries exist and mainstreaming occurs, the ability to effect policy depends on the relative influence of the ministry itself or structures within the government and to what extent it is committed to gender equality.

Moreover, despite increasing international attention, civil society continues to lead most efforts to engage men and boys. This means that programmes tend to be small-scale, of short duration and reaching only a small number of men. Very few have been scaled up or institutionalized at the governmental level.

Governments have the capacity to take programming with men and boys to a far larger scale than civil society. National policies in support of gender equality can create the context for legislation, regulations, and government programmes that lead to larger, faster and broader change in men's attitudes and behaviours.

Policies that engage men and boys within a framework of gender equality have been shown to have impact, although there is fewer examples to draw from compared to gender policy in general. Still, it has been shown that such policy initiatives can lead to positive impact on gender equality and in the health of women, children and men.

Perhaps some of the best-known examples of successful policies are those related to paternity leave in the Scandinavian countries. These are designed to encourage male involvement in parenting but many studies show that it is also beneficial to children. In Norway and Sweden, for example, public policies effectively encouraged new fathers to take paternity leave. This in turn led to greater participation by fathers in the care of newborns and infants and greater workforce participation by women (Pylkkänen and Smith, 2004).

BOX 2**WHAT IS MEANT BY POLICY?**

Policy, and especially public policy, refers to governmental plans, positions and guidelines, which guide and determine present and future decisions. Policy includes plans outlining how to reach a certain goal and the rules that guide how to implement that plan in addition to how it is reflected in government legislation, regulations and public programmes.

Policy development is generally a political activity, although it is often influenced by the perceived priorities of government constituents and often by civil society and private sector corporations and industry associations. Frequently, developing policy includes researching various options, consulting with different stakeholders, and choosing the best option. Organizations or individuals attempt to influence each step of the process.

CASE STUDY 1

MENENGAGE

MenEngage is a global alliance of NGOs and UN agencies that seeks to engage boys and men to achieve gender equality. International Steering Committee Members include International Center for Research on Women (co-chair), Sonke Gender Justice (co-chair), EngenderHealth, the International Planned Parenthood Federation, Family Violence Prevention Fund, Instituto Promundo, Save the Children-Sweden, Sahoyog, and the White Ribbon Campaign. The Alliance of more than 400 NGOs from around the world was founded in 2004 with the general goal of working together to promote the engagement of men and boys in achieving gender equality and health. A core strategy of the alliance is to use

evidence from programming to dialogue with policy makers on the importance of a scaling up of successful initiatives with men and boys and addressing structural barriers to achieving gender-equality. Country networks exist in every region and have included activities such as workshops, dialogue with government, advocacy, and the implementation of campaigns including the White Ribbon campaign.

FOR MORE INFORMATION: WWW.MENENGAGE.ORG

CASE STUDY 2

GENDER POLICY IN SOUTH AFRICA

South Africa stands out as having an integrated and far-reaching policy framework for promoting gender equality, and creating monitoring mechanisms to assess implementation. Called the "Gender Machinery", it has the goal of implementing and monitoring South Africa's compliance with UN conventions related to gender, to propose national law, and to promote gender equality within the national, provincial and municipal governments. Included within this national "apparatus" is a "men and gender equality programme", which

includes work to train staff and policymakers in engaging men in gender equality and some efforts to achieve more coordination within existing civil society and governmental efforts to engage men (e.g. examining ways to engage men in care and support through existing HIV services, engaging men in existing wellness and community social services). The "Gender Machinery" also includes efforts to take messages related to gender equality into the public school system.

CASE STUDY 3

THE MEN & GENDER EQUALITY POLICY PROJECT

Coordinated by the International Centre for Research on Women (ICRW) and Instituto Promundo, this multi-country project seeks to raise awareness among policy-makers and programme planners of the need to involve men in health and development and to provide them with high-impact, feasible and practical strategies concerning how to change the attitudes and behaviour of young and adult males as they relate to SRH, GBV, fatherhood and maternal and child health. The project is currently taking place in Brazil, Cambodia, Chile, Croatia, India, Mexico and South Africa and includes the following activities:

- Policy research and analysis on the potential points of leverage for changing male gender norms and men's behaviours related to SRH and maternal and child health. This research involves developing national and comparative policy tools for analyzing existing policies and identifying strategies for achieving large-scale change related to men.
- The International Men and Gender Equality Survey (IMAGES), a standardized questionnaire (one applied with women and one with

men: 1000 of each) to measure male behaviour and attitudes on a range of issues related to gender equality. This survey is based on a Norwegian questionnaire for women and men on male behaviours and attitudes, GBV, fatherhood, SRH, domestic work and work-life balance. Additional questions are being added from a South African survey on violence, and from the Gender Equitable Men (GEM) Scale.

- In-depth qualitative interviews with men engaged in care giving professions or in "non-traditional" care giving activities in their personal lives. What led these "pioneers" to this work? What kinds of resistance and affirmation have they encountered? This research will provide insights into the deeper processes of social change in diverse settings.

FOR MORE INFORMATION: WWW.ICRW.ORG OR
WWW.PROMUNDO.ORG.BR

TOOLS

Building Alliances

Dealing with the Opposition

How to prepare for lobbying or a face-to-face meeting

How to write a press release

How to write a letter to the editor

**Needs Assessment,
Monitoring And
Evaluation**



Determining whether specific programmes lead to lasting and real change in the attitudes and behaviours of men and boys—let alone in the social construction of gender—can be challenging. Existing evaluation research offers uneven levels of data, varying rigour in the application of evaluation methods, a variety of measures or indicators (attitudes, knowledge, behaviour and effects on policy) and the common challenge of social desirability (distinguishing between actual behaviour and attitudes and the fact that men may tell researchers what they think they want to hear).

Nevertheless, the number of health-related programmes targeting men and boys and based on a gender perspective has been growing during the past 15 years. Most of these have been at the programme level and generally focus on several health areas, most notably: Sexual and reproductive health (SRH); HIV prevention, treatment, care and support; maternal, newborn and child health (MNCH); fatherhood and GBV. Accompanying these programmes has been an increase in rigorous evaluations and the evidence of the positive impact on male attitudes and behaviours (see Box 3 in the Introduction). More evidence is needed, to be sure, and such programmes have been mostly small scale and short term.

Evaluation is a fundamental part of programme efforts to engage men and boys in health promotion. It can demonstrate the impact of activities and help to

identify gaps and directions for future work. Moreover, evaluation can bolster advocacy efforts by providing policymakers with evidence of the benefits. Too often, however, programmes do not undertake adequate evaluation of their activities owing to a variety of reasons. These include lack of:

- Financial or material resources;
- Qualified and experienced personnel;
- Organizational experience with evaluation;
- The fact that it is not always easy to collect information about some issues related to health and relationships (e.g. sexual behaviours and use of violence) owing to the delicate nature of these topics.

Moreover, caution must be exercised with how much to attribute to certain outcomes and indicators. On the surface, for example, increased condom use among men and use of health services do not inherently reduce gender inequality—unless they also reduce the burden of contraception on women or represent a measureable change in how men view and interact with women.

To help address these different considerations and challenges, this module provides brief explanations related to key steps in the evaluation process and a set of tools specifically related to programmes that engage men and boys.

NEEDS ASSESSMENT

A needs assessment is the process of defining the various factors that influence the attitudes and behaviours of men and boys related to specific health themes in a specific context; the gaps in access to, and quality of, existing information; programmes and services and; subsequently, the types of interventions that would help to address these gaps.

It can include carrying out research firsthand and/or collecting and analyzing data from secondary sources. **The research and/or data highlighted should feature the voices and reflections of men and boys**

themselves, as well as those who interact with them and influence their attitudes and behaviours—such as intimate partners, parents, teachers, and community leaders, among others. As part of the needs-assessment process, it is worthwhile to also identify other organizations that work, or are interested in, engaging with men and boys. These organizations might be able to furnish data and instruments from their own studies and can also be valuable collaborators in the design and implementation of interventions and advocacy activities.

PLANNING

After the needs assessment, the next step is to develop intervention objectives and strategies (such as educational activities, health services, community campaigns and/or advocacy) and to define the duration, number and variety of individuals to be engaged, etc. It is also during this planning phase that the monitoring and evaluation plan and instruments are developed. An important tool for planning, in addition to monitoring and evaluation, is the log frame (see Tools "Logframe"). It entails defining and describing goals, activities, indicators, means of verification and risks/assumptions related to the successful implementation of the project and, when used accurately and consistently, can help in the design, implementation, monitoring and evaluation of the project. Other helpful tools include a detailed work plan and timeline.

BOX 1

NEEDS ASSESSMENT PACKAGE FOR MALE ENGAGEMENT PROGRAMMING

EngenderHealth/ACQUIRE Project and Instituto Promundo developed a package for carrying out a needs assessment to identify gaps in male engagement programming related to HIV/AIDS prevention, treatment, care, treatment and support. The package includes a set of questionnaires designed to help gather firsthand information on existing programmes and policies in a particular setting and to gauge the commitment and capacity of key institutions and stakeholders to integrate male gender norms in

HIV and AIDS prevention, treatment, care, support and treatment.

The questionnaire for health services professionals is included in the tools section. With slight adaptations, this and the others in the package could be utilized for needs assessment featuring men, boys and other health themes.

AVAILABLE FOR DOWNLOAD AT: WWW.AIDSPORTAL.ORG/

BOX 2

PLANNING QUESTIONS

- What are the goals of the intervention?
- Who will be the target population(s)? How will they be engaged?
- Who are the main stakeholders?
- How will the community and its leaders be engaged in the development and implementation of the project?
- What strategies will be used to reach these goals?
- What is necessary to ensure that the intervention is a success?
- What potential barriers exist to success?
- What indicators will be used to measure success?
- What problems may occur during implementation? How will they be addressed?

MONITORING

Monitoring is the process of ensuring that activities are implemented as planned and identifying necessary adjustments in the work plan and/or use of resources. A monitoring plan should be developed prior to the onset of activities and should include process indicators such as financial resources and time expended (quantitative) and response and feedback from staff and participants (qualitative). For example, the monitoring of educational workshops can include tracking of the number of sessions and participants present at each session (quantitative) in addition to weekly meetings between the evaluation team and the facilitators and activity reports which the facilitators complete after each workshop session (qualitative).

EVALUATION

Evaluation is defined as, "a time-bound exercise that attempts to assess systematically and objectively the relevance, performance and success, or the lack thereof, of ongoing and completed programmes" (UNFPA, 2004). The monitoring and evaluation plan should be developed at the project design stage just as the indicators are being selected for the project.

In organizing an evaluation plan, the following questions can be a useful guide (UNFPA, 2004):

1. WHY: What is the goal of the intervention and evaluation and who should benefit from the results? The beneficiaries can include the target population as well as implementing organizations and the broader field of research.

EXAMPLES:

- Was the intervention successful in preventing the transmission of HIV among men and women living within a specific community?
- Did the intervention result in an increase in condom usage by men in their last sexual relation with fixed partners?
- Are men using condoms more often than before the intervention?
- Do the results contribute to a discussion at the federal or local level regarding public policies that address men and boys?
- Did the project increase the amount of time men dedicated to direct care-giving to infants?
- Did the project reduce reported incidences of violence against women?

2. HOW: What would be the best evaluation design? Will there be a pre-test (before the intervention) and a post-test (after the intervention) or only a post-test? Will all the data be quantitative, qualitative or both? Will there be a control group? (See Tools "Qualitative Focus Group Guide" and also Tools "GEM Scale", a quantitative questionnaire).

3. WHO: Who will coordinate and work on the evaluation? Are they familiar with quantitative and/or qualitative research methods and data analysis? How will stakeholders and young men be involved (not necessarily the same young men who will be direct beneficiaries of the intervention, but peer representatives)?

4. HOW MUCH: How much money will be needed to carry out the evaluation? In general, qualitative evaluations are less costly, but require more time for analysis. Quantitative evaluations, on the other hand, are generally more expensive owing to the cost involved in hiring and training interviewers, producing copies of questionnaires, and entering and cleaning the data. Box 3 presents the scale of resources needed for different research designs—even when resources are very limited, it is important to incorporate some minimal package of evaluation into the design of the programme.

The evaluation process can be a considerable investment in technical and financial terms, but it is highly necessary to ensure that resources are maximized and that programme efforts are effective.

There have been many innovative efforts to engage men and boys in the health promotion, however, too few of these efforts have been adequately evaluated and documented. For programmatic purposes, as well as funding and advocacy ones, it is important to increase the body of evaluation studies with respect to working with men and boys as well as the dissemination and exchange of lessons learned and recommendations.

BOX 2

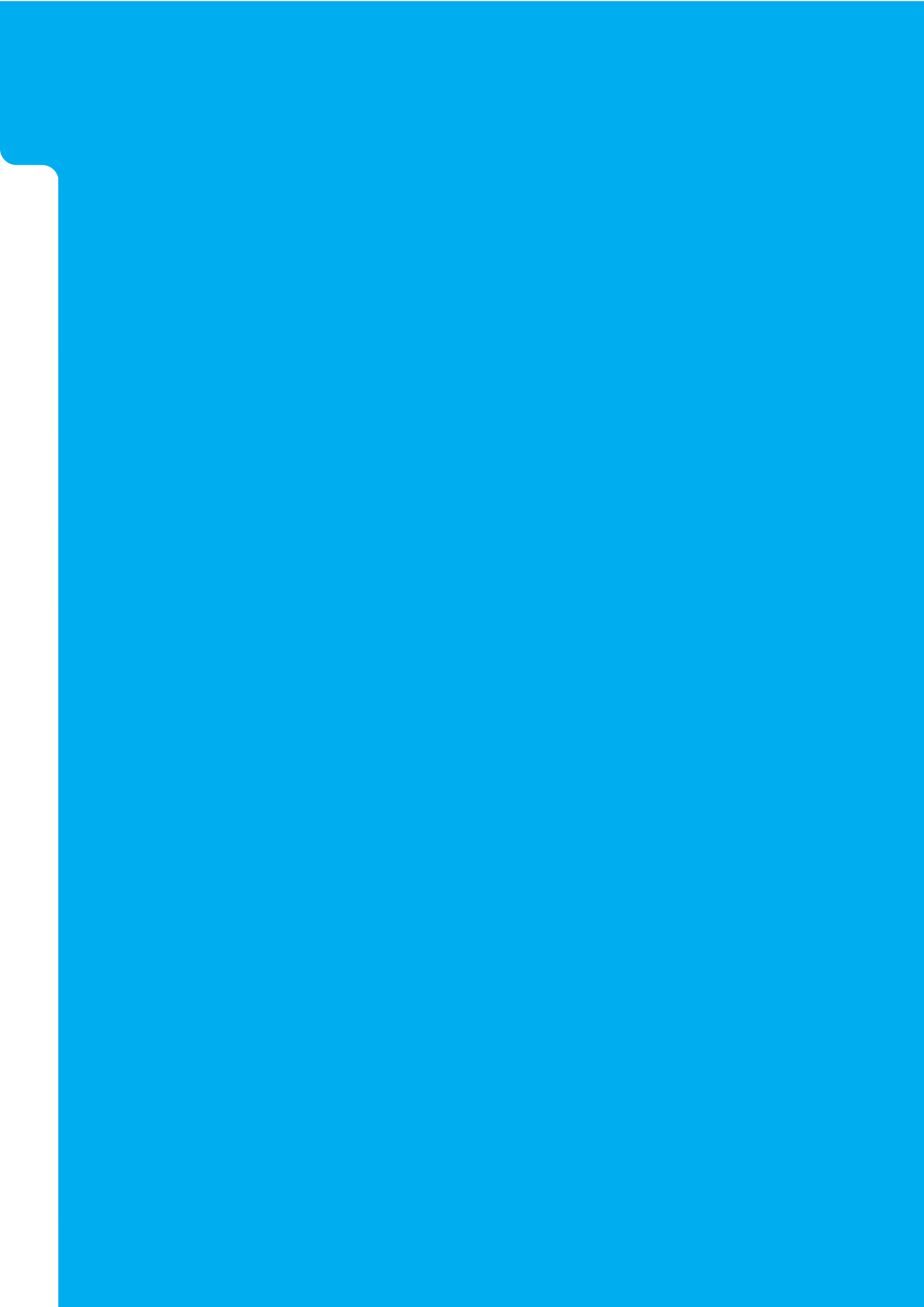
TYPES OF EVALUATION “PACKAGES” BY AMOUNT OF RESOURCES

- Very limited resources = needs assessment + process evaluation + pre and post qualitative
- Limited resources = needs assessment + process evaluation + pre and post quantitative and qualitative
- Modest resources = needs assessment + process evaluation + pre and post quantitative and qualitative + control group
- Sufficient resources = needs assessment + process evaluation + pre and post quantitative and qualitative + triangulation (e.g. in-depth interviews with partners) + control group

TOOLS

Organizational Self-evaluation
Health Facilities Staff Needs Assessment
Sample Logical Framework
The Gender Equitable Men Scale

Gender Transformative Programming



Education:

Understanding the Gender Continuum¹

OBJECTIVE

To understand the continuum of gender as it relates to media campaigns and programmes

TIME

60 minutes

MATERIALS

Copies Handout 1: Project Case Studies

PROCEDURE

1. Explain that we've been exploring the importance of understanding how gender can affect our project outcomes and why male involvement is critical to a successful outcome. Many people in this field use a continuum to assess how gender is addressed: on one end it is harmful and promotes gender inequity but then it gradually moves towards actively promoting equality between the genders. This continuum includes four categories. Display flipchart with the continuum and the categories:

Exploitative: Projects that exploit gender inequalities and stereotypes in pursuit of health and demographic outcomes.

Neutral (blind): The project does not attempt to address gender.

Sensitive (accommodating): Projects that accommodate gender differences in pursuit of health and demographic outcomes.

Transformative: Projects that seek to transform gender relations to promote equity as a means to reach health outcomes.

2. Briefly review the following examples to illustrate these categories:

- The goal of a social marketing campaign undertaken in Latin America and the Caribbean was designed to increase condom sales. The campaign capitalized on social and cultural values that focus on male virility, sexual conquest, and control. It depicted macho men having multiple female partners and thus reinforced gender inequality—thus it could be defined as "gender exploitative".

- A social marketing campaign in Brazil utilized images of men in caring and equitable roles with the tag line roughly translated to mean "A real man....cares, respects and takes on responsibility." Though the campaign marketed condoms it also marketed a gender equitable lifestyle to young men that would also be seen as "cool" —i.e. a "gender transformative" intervention.

Tell the participants that next they will have an opportunity to look at a project description and determine where it falls on the continuum.

3. Do the following:

- Divide the large group into an even number of pairs or triads (sets of three).
- Explain that you have four to six project examples (once again, it depends on the size of the group), with two copies of each example.
- Give each set of pairs/triads a project description.
- Tell the triads/pairs to read their project description and, as a triad/pair, determine where the project fits on the gender continuum. When they have decided, they should tape their description where they believe it belongs on the continuum: exploitative, neutral, accommodating, or transformative.
- Tell the group they have 15 minutes for this activity.

* Facilitator Note: You want to have at least one project description for each category.

4. After the triads/pairs have placed their project where they believe it belongs on the continuum, moving across the continuum, ask a representative from each triad to come up and read their project description and explain why they decided it belonged on that spot on the continuum. Ask if people agree with the placement. If not, discuss where it should go.

5. Once this has been done, explain to the groups that you are going to be discussing various media campaigns and where the fit on the continuum. Explain that you will be doing this as a group. Give them examples of other programs either in discussion, as handouts or on a powerpoint

¹ Adapted from a training curriculum developed by EngenderHealth

presentation and discuss where they would fit on the continuum. If any of them are examples of a gender transformative approaches, ask the participants how they could have been made more gender transformative.

DISCUSSION QUESTIONS

Debrief the activity by asking the following questions:

- Was this exercise easy? Difficult? Why?
- What helped you determine where it needed to be placed?
- Could the project descriptions or campaigns fit in more than one place on the continuum?
- Were there any surprises?
- What is the "take home" message from this exercise? (It's a missed opportunity if we do not build gender into our projects. If we do not build it in, it can have a negative effect or unintended consequences.)

CLOSING

End the discussion by reminding the participants that we should always be working towards developing gender transformative projects. It may not always be possible right away, but we should aim for it. Additionally, it is important to ensure that programmes and campaigns are never gender exploitative even if they can assist you to reach your programme goals.

Handout 1

FEMALE CONDOM PROMOTION IN PROJECT CASE STUDIES

A pilot programme was designed to increase the acceptability and use of the female condom in South Africa. Historically, female condoms have been promoted to women. After acknowledging that in the African context men dictate the terms of heterosexual encounters, the programme decided to try an innovative approach: Promoting the female condom to men via male peer promoters. This involved:

1. Male promoters demonstrating to men the use of the female condom;
2. Explaining to them that self-protection and sexual pleasure are completely compatible with the use of the female condom—especially when compared to currently available barrier alternatives, and
3. Giving men female condoms to use with their female partners.

CAMPAIGN TO INCREASE MALE INVOLVEMENT IN ZIMBABWE

In an effort to increase contraceptive use and male involvement in Zimbabwe, a family planning project initiated a communication campaign promoting the importance of men's participation in family planning decision-making.

Messages relied on sports images and metaphors, such as, "play the game right, once you are in control, it's easy to be a winner" and "It is your choice". When evaluating impact, the project asked male respondents whether ideally they, their partners, or both members of the couple should be responsible for making family planning decisions.

The evaluation found that although the campaign did indeed correspond to increased contraceptive use it resulted in some unintended consequences. To wit: "whereas men were far more likely to believe that they should take an active role in family planning matters after the campaign, they did not necessarily accept the concepts of joint decision-making. Men apparently misinterpreted the campaign messages to mean that family planning decisions should be made by men alone."

YOUTH OUTREACH IN THE DOMINICAN REPUBLIC

A health project in the Dominican Republic was concerned about rising STI and pregnancy rates among youth. Unable to convince the public school system to incorporate a reproductive health curriculum in the high schools, the programme decided to instead recruit volunteer peer educators to conduct charlas, or informal discussion groups. In order to do so peer educators held after-school neighbourhood youth charlas in mixed-sex groups, to discuss issues related to dating, relationships, reproductive health, and contraception (including condoms). They also provided information on where contraceptives could be obtained.

FGM/C PREVENTION PROGRAMME IN KENYA

A Female Genital Mutilation Cutting (FGM/C) intervention in Kenya sought to reduce the incidence of harmful cutting. Project staff realized that creating a law that would prohibit the practice would not be sufficient on its own for addressing the cultural and social motivations of the community, and would likely result in driving the practice “underground”.

Instead, the project hired a medical anthropologist to work with the community. Through qualitative interviews with groups of women, men, and religious leaders, the project sought to understand the meaning and functions that the ritual provides to the community. Together with community members, the project staff adapted the FGM/C ritual by eliminating the harmful cutting but keeping the positive values: Dance, story-telling, gift-giving, health and hygiene education, etc. As a result, a new right-of-passage ritual has been created for girls called “circumcision with words”, which has become accepted by the entire community.

CULTURAL RESOURCES AND MATERNAL/CHILD HEALTH IN MALI

A child survival project in Mali, aiming to reduce morbidity and mortality rates among children and women of reproductive age, focused on using indigenous knowledge and cultural resources to increase and improve communication and health-seeking behaviour during pregnancy. Research showed that one of the most important obstacles to maternal health care-seeking behaviours was the absence of discussion about pregnancy between husbands and wives, as well as with other members of the household.

Local women felt that they could not take advantage of maternal services because they could neither initiate conversations with their husbands nor solicit their consent and financial support as the heads of the household. The project staff asked a griot, (traditional story teller) to compose a song that educated people about maternal health care, along with promoting the *pendelu*—a traditional article of women's clothing—as a symbol of pregnancy and couple communication.

This campaign dramatically increased the level of communication between wives and husbands concerning maternal health. Additionally, it also resulted in more positive attitudes and behaviours related to pregnancy at the household level. More husbands reported supporting their wives by helping them to reduce their workload, helping them to improve their nutrition, and urging them to seek medical attention and maternal health services.

HAND WASHING FOR DIARRHEAL DISEASE PREVENTION IN CENTRAL AMERICA

The Central American Hand washing Initiative aimed to reduce morbidity and mortality among children under the age of five through a communication campaign promoting proper hand washing with soap to prevent diarrheal disease. Four soap companies launched hand washing promotion campaigns; radio and television advertisements; posters and flyers; school, municipal and health centre programmes; distribution of soap samples; promotional events; and print advertisements. The basic approach was to present a mother as caretaker of the family and to describe or illustrate the three critical times for hand washing: before cooking or preparing food; before feeding a child or eating; and after defaecation, cleaning a baby, or changing a diaper. They also emphasized essential aspects of hand washing technique: use water and soap, rub one's hands together at least three times, and dry them hygienically.

YOUTH ROLES IN CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV/AIDS (PLWHA)

In Zambia, one project has sought to involve young people in the care and support of People Living with HIV and AIDS. This project carried out formative research to assess young people's interest and to explore the gender dimensions of care. The assessment explored what care-giving tasks male and female youth felt more comfortable about undertaking, as well as what tasks People Living with HIV and AIDS themselves would prefer having a male or female youth carry out. Based on this research, the project adopted an approach that incorporates preferred tasks for young women and young men in order to develop youth care and support activities for People Living with HIV and AIDS.

Education:

Learning About Gender²

OBJECTIVES

1. To understand the difference between the terms "sex" and "gender"
2. To understand the terms "gender equity" and "gender equality"

TIME

45 to 60 minutes

MATERIALS

- Flipchart
- Marker
- Tape
- Enough copies of Handout 2: The Gender Game for all participants

PROCEDURE

1. Explain that this session will help clarify some of the terminology that we will be using in the workshop. It will also help us to understand what these terms mean in our own lives.
2. Ask participants if they can explain the difference between "sex" and "gender." After soliciting feedback, provide the following definitions:
 - Sex refers to physiological attributes that identify a person as male or female.
 - Gender refers to widely shared ideas and expectations concerning women and men. These include ideas about typically feminine/female and masculine/male characteristics and abilities in addition to commonly shared expectations about how women and men should behave in various situations.
3. Distribute the handout and ask the participants to indicate if the statements are referring to "sex" or "gender." After giving the participants a chance to read and answer the statements on their own, discuss each of the answers with the entire group.
4. Explain that there are several terms related to the word "gender", that also need to be explained. Ask the group if they have ever heard the term

"gender equality". Ask them what they think it means. Allow plenty of time for discussion.

5. After getting their feedback provide the following definition:

Gender Equality means that men and women enjoy the same status. They share the same opportunities to realize their human rights and the potential to contribute and benefit from all spheres of society (economic, political, social, cultural).

6. Ask the group if the definition makes sense. Allow them to ask questions.

7. Ask the group to discuss whether or not gender equality actually exists in their country.

As the group discusses this, write down any statements that explain why women do not share equal status with men. Be sure to include some of the following points if they are not mentioned by the group:

- Women in many countries are more likely than men to experience sexual and domestic violence.
- Men are paid more than women for the same work (in most cases).
- Men occupy more positions of power within the business sector.
- Women bear the brunt of the AIDS epidemic, both in terms of total infections, but also with respect to caring and supporting those living with HIV.

8. Ask the group if they have ever heard the term "gender equity." Ask them what they think it means and how it is different from gender equality. Allow plenty of time for discussion. After collecting their feedback provide the following definition:

Gender Equity is the process of being fair to men and women. Gender equity leads to gender equality. For example, an affirmative action policy that increases support to female-owned businesses may be gender equitable because it contributes to equal rights between men and women.

² Adapted from "Engaging Men and Boys in Gender Transformation: The Group Education Manual", developed by EngenderHealth and Promundo for USAID

DISCUSSION QUESTIONS

After clarifying the definitions of gender equality and gender equity, ask the group the following questions:

- Why should men work towards achieving gender equality?
 - What benefits does gender equality bring to men's lives?
 - How does gender inequity contribute to HIV infection?
 - How can gender equity contribute to preventing HIV?
 - Ask the group to identify gender-equitable actions that men can take to help create gender equality.
5. Many women do not make decisions with freedom, especially regarding sexuality and couple relationships.
 6. The number of women with HIV (human immunodeficiency virus) infection and AIDS (acquired immunodeficiency syndrome) has increased steadily worldwide.
 7. Four-fifths of the world's injecting drug users are men.
 8. Women get paid less than men for doing the same work.

CLOSING

A major goal of promoting gender equality is to encourage communities to be more gender-sensitive and to prevent HIV infection so that men and women can live healthier and happier lives.

To achieve this, we must encourage gender-equitable behaviours. These include joint decision-making about health issues that effect both men and women, respect for the right of a woman to refuse sex, settling differences without violence, and shared responsibility with respect to parenting and taking care of others.

Handout 2

THE GENDER GAME

Identify if the statement refers to gender or sex:

1. Women give birth to babies, men don't.
2. Girls should be gentle: boys should be tough.
3. Women or girls are the primary caregivers for those sick with AIDS-related illnesses in more than two-thirds of households worldwide.
4. Women can breastfeed babies, men can bottle feed babies.

ANSWERS:

1. Sex
2. Gender
3. Gender
4. Sex
5. Gender
6. Sex and Gender
7. Gender
8. Gender

Education:

Act like a man, Act like a woman³

OBJECTIVE

To recognize the challenges men and women face in trying to fulfill societal expectations about gender roles, understand the costs and convey that it is possible to change.

MATERIALS

Flipchart paper, markers, and tape

TIME

45 minutes

PROCEDURE

1. Ask the participants if they have ever been told to "act like a man" or "act like a woman" based on their gender. Ask them to share some experiences in which someone has either made the same remark or said something similar to them. Why did the individual say this? How did it make the participant feel?

2. Tell the participants that we are going to look more closely at these two phrases. By looking at them, we can begin to see how society can make it very difficult to be either male or female.

In large letters, print out on a piece of flipchart paper the phrase: "Act Like a Man." Ask the participants to share their ideas about what this means. These are society's expectations of who men should be, how men should act, and what men should feel and say. Draw a box and write what it means to "act like a man" inside this box. Some responses might include the following:

- Be tough.
- Do not cry.
- Show no emotions.
- Take care of other people.

3. Now in large letters, print the phrase: "Act Like a Woman." Ask the participants to share their ideas about what this means. These are society's expectations of who women should be, how women should act, and what women should feel and say. Draw a box on the piece of paper, and write the meanings of "act like a woman" inside this box. Some responses may include the following:

- Be passive.
- Be the caretaker.
- Act sexy, but not too sexy.
- Be the homemaker.

4. Next, draw another table that includes columns representing men and women. Label it: "Transformed Men/Women." Ask the participants to list characteristics of men who are "living outside the box." Record their answers. Once you get seven or so responses, ask the same about women who are, "living outside the box." Help the participants recognize that, in the end, characteristics of gender equitable men and women are actually similar.

5. Once you have brainstormed your list, initiate a discussion by asking the questions below.

DISCUSSION QUESTIONS

- Can it be limiting for a man or woman to be expected to behave in this manner? Why?
- What emotions are women not allowed to express?
- How can, "acting like a woman" affect a woman's relationship with her partner and children?
- How can social norms and expectations to, "act like a woman" have a negative impact on a woman's sexual and reproductive health?
- Can women actually live outside the box? Is it possible for women to challenge and change existing gender roles?
- Can it be limiting for a man to be expected to behave in this manner? Why?
- What emotions are men not allowed to express?
- How can "acting like a man" affect a man's relationship with his partner and children?
- How can social norms and expectations to, "act like a man" have a negative impact on a man's sexual and reproductive health?

³ Adapted from "Men as Partners: A Programme for Supplementing the Training of Life Skills Educators" developed by Engender Health and The Planned Parenthood Association of South Africa. For more information visit the Engender Health website: www.engenderhealth.org/ia/www/mwmo.html

- Can men actually live outside the box? Is it possible for men to challenge and change existing gender roles?
- What would make it easier for men and women to live outside of these boxes?

CLOSING

The roles of men and women are changing and it is becoming easier to step outside of the box. Still, it is hard for men and women to live outside. We need to be aware of the vulnerabilities we face when we live in these boxes and the benefits to be gained from living outside of them.

Education:

Persons and Things⁴

OBJECTIVE

To increase awareness about the existence of power in relationships and reflect on how we communicate about and demonstrate power in relationships.

MATERIALS

None

TIME

1 hour and 30 minutes

PROCEDURE

1. Divide the participants into two groups with an imaginary line. Each side should have the same number of participants.

2. Tell the participants that the name of this activity is Persons and Things. Choose at random one group to be the "things" and one group to be the "persons".

3. Read the following directions to the group:

a) **THINGS:** You cannot think, feel, or make decisions. You have to do what the "persons" tell you to do. If you want to move or do something, you have to ask the person for permission.

b) **PERSONS:** You can think, feel, and make decisions. Furthermore, you can tell the things what to do.

NOTE: It might be helpful to ask for two volunteers to first act out for the group how a "person" might treat a "thing".

4. Ask the "persons" to take the "things" and do what they want with them. They can order them to do any kind of activity.

5. Give the groups five minutes for the "things" to carry out the designated roles.

6. Finally, ask the participants to go back to their places in the room and use the questions below to facilitate a discussion.

DISCUSSION QUESTIONS

- For the "things": How did your "persons" treat you? What did you feel? Why? Would you have liked to be treated differently?
- For the "persons": How did you treat your "things?" How did it feel to treat someone as an object?
- Why did the "things" obey the instructions given by the "persons?"
- Were there "things" or "persons" who resisted the exercise?
- In your daily life, do others treat you like "things?" Who? Why?
- In your daily life, do you treat others like "things?" Who? Why?
- Why do people treat each other like this?
- What are the consequences for a relationship when one person treats another as a "thing"?
- How does society/culture perpetuate or support the kinds of relationships where some people have more power over other people?
- How can this activity help you think about and perhaps make changes in your own relationships?

CLOSING

There are many different types of relationships in which one person might have more power over another person. The unequal power balances between men and women in intimate relationships can increase the risk of STIs, HIV/AIDS, and unplanned pregnancy. For example, a woman often does not have the power to say if, when, and how sex takes place, including whether a condom is used, because of longstanding beliefs that men should be active in sexual matters and women should be passive (or that women "owe" sex to men). In other cases, a woman who is dependent on a male partner for financial support might feel

⁴ Adapted from the Programme H manual developed by four Latin American NGO's: Promundo (Rio de Janeiro, Brazil - coordination), ECOS (São Paulo, Brazil), Instituto PAPA (Recife, Brazil), and Salud y Género (Mexico). For more information about Programme H see www.promundo.org.br

that she does not have the power to say "no". In cases of cross-generational sex, age, economic and class differences can further create unequal power relations between men and women that can lead to risk situations.

Think other examples of power relationships in your lives and communities: between youth and adults, students and teachers, employees and bosses. Sometimes power imbalances in these relationships can lead one person to treat another like an object. As you discuss gender and relationships between men and women, it is important to remember how in other relationships you might feel oppressed, or treated like an "object" and how you in turn might treat others, including women, as "objects." Examining about these similarities can help motivate you to construct more equitable relationships with women both at home and in the community.

Education:

Tips for Facilitators⁵

- Establish ground rules around listening, respect for others, confidentiality, and participation.
 - It is important to have a suitable physical space where activities can be carried out without any restriction of movement. Avoid classroom-style sitting arrangements. Instead, have the participants sit in a circle to promote more exchange during discussions. The space should also be private in the sense that men and/or boys should feel comfortable discussing sensitive topics and airing personal opinions.
 - Encourage as much physical movement as possible to keep the participants alert and interested.
 - Be friendly and create rapport with your participants.
 - Be sure to dress appropriately. You should look approachable, but also professional.
 - Remember that information should be provided in non-authoritarian, non-judgmental, and neutral way. You should never impose your feelings on the participants.
 - Be conscientious of the language and messages which are presented to young men.
 - Remember that, although young men often act as if they are sexually knowledgeable they often have concerns about relationships and sexual health.
 - Involve the men in choosing discussion themes but encourage them to be personally meaningful. Remember to always reflect on activities and ask the participants how they can apply what they have learned in their own lives.
 - Young men respond well to participatory style activities that are entertaining and educational. For example, role-playing allows young men to explore problems they might not feel comfortable discussing in other settings. It also helps young men practice various skills, such as negotiation, refusal, and decision-making as well as how to use a condom correctly. Remember that some men may not be comfortable with physical contact during role-playing or with taking on the role of female characters. An alternative to role-play is to initiate a debate where participants will need to argue from a perspective they might not normally entertain.
 - Do not aim to instil fear. Men or boys will often "switch off" or feel paralyzed.
 - Encourage participants to be honest and open: They should not be afraid to discuss sensitive issues. Encourage the participants to honestly express what they think and feel, rather than only say what they think the facilitator wants to hear.
 - If a participant makes an exaggerated statement or disseminates misinformation and/or myths during a discussion, request clarification and be sure to provide accurate facts and information. You can also ask if another participant has a different opinion, or if no one provides one, you can offer your own along with facts to support your view.
 - Check your own assumptions. Be aware of whether participants from particular social, cultural, or religious backgrounds seem to trigger strong emotions in you. Use your reaction as an opportunity to reflect and reach past your own assumptions or prejudices.
 - Have regular check-ins. These can usually occur at the beginning of each session and could involve the following questions:
 1. How have you been since we last met?
 2. Has anything new happened?
 3. Have you talked to anyone about the issues we discussed in our last session?
- If important issues come up during the check-in, do not be too rigid about the planned agenda. Allow some space to deal with the young men's issues.
- Provide further resources so that participants can obtain more information or support about the issues discussed in the workshop. For example, you may need to tell participants where to obtain condoms or go for voluntary counselling and testing.

⁵ Adapted from "Engaging Men and Boys in Gender Transformation: The Group Education Manual", developed by EngenderHealth and Promundo for USAID.

Services:

Checklist for Gender Friendly Health Services⁶

This checklist is designed to help assess whether a health service is friendly to both men and women and to identify gaps that need to be addressed.

- It is easy for a man or boy to schedule an appointment.
- Staff who interact with men and boys (e.g. health care providers, lab technicians, health educators, social workers, and receptionists) should be trained to listen to, and counsel men and boys in a non-judgmental and culturally appropriate manner.
- During each consultation/visit, clients are provided with comprehensive information and services that respect differences in social class, family values, maturity, race and/or ethnicity.
- Men and boys are treated in a holistic manner during each visit—that is, both their medical and social needs are evaluated. Should access to a social worker or referral to a specialist be necessary, this process should be made as simple as possible for the young man. (This includes identifying specialists and social workers that are accustomed to working with men — and in particular young men.)
- The facility is open during hours that do not conflict with school or work. (This often requires evening and weekend hours.)
- It is easy for men, especially young men, to acquire condoms or required medications.
- Men and boys are informed that their right to privacy and confidentiality will be respected and that all staff will uphold these policies.
- Doctors and nurses feel comfortable speaking with men and boys about sexual behaviours and HIV and STI prevention.
- Educational activities are conducted where peer educators can discuss the importance of sexual and reproductive health care. When targeting youth these activities should be conducted in separate, youth-only spaces. However, waiting rooms are also okay.
- When educational activities are not being conducted, some form of entertainment should be made available, e.g., magazines or a TV featuring sports or other entertainment shows.
- The facility décor is attractive to men and boys and includes pictures of men engaging in health-promoting behaviours, e.g. holding and/or feeding babies.
- The services provided for men and boys are well advertised in the community. For example, clinic staff regularly attend community events popular with men and boys, such as school dances or sporting events to distribute information regarding clinic services.
- Referral relationships have been established with organizations and clinics that specialize in male health issues.
- The service provider recognizes that many men have fears and anxieties about seeking health care services. Community-specific promotional materials, such as videos or pamphlets must be developed to address these issues.

⁶ Adapted from McIntyre (2002) and Armstrong (2003)

Campaigns:

Creating a Campaign - Step by Step⁷

Below are the steps necessary to develop a campaign that incorporates a gender perspective. The length of time necessary for these will vary depending on available resources and can range from weeks to months. It is important that young men be involved in aspects of the development process—the 'steps'. Often young men are only involved as needs-assessment respondents or as focus group participants to 'test' campaign images and messages. However, campaigns are more likely to be engaging and effective when youth are involved during every stage of the process.

UNDERTAKE A NEEDS-ASSESSMENT

This should include gathering information about the gender-related attitudes of men and boys, and their knowledge, behaviours and practices related to the health issue to be addressed. It should also include a mapping of media and social networks, which could be tapped as part of the campaign strategy.

DEVELOP A PROFILE OF A 'TYPICAL' YOUNG MAN FOR EACH OF THE CAMPAIGN TARGET AREAS OR POPULATIONS

A useful technique for laying out the characteristics of the target group is to create a character profile. This involves developing a profile of a 'typical' man or boy from the target group; thinking about various characteristics including: socio-demographics, hobbies, attitudes about gender roles, sexual behaviours including condom-use and the number and type of partners, access to and use of social services and programmes, health knowledge and general aspirations. It can also be helpful to name this man and to create a physical appearance.

Although this technique requires a degree of generalization about the target group, it is not intended to diminish the diversity that exists among men, but rather, to assist in the process of developing messages and strategies which would be attractive to, and appropriate for, the target group as a whole.

DEFINE SUB-THEMES FOR THE CAMPAIGN

Within the themes of gender-equity and health, it is necessary to identify sub-themes—such as communication with partners about sex and condom use; speaking out against violence or in support of care-giving and fatherhood—which will form the basis for the campaign. These sub-themes should be defined based on what the needs-assessment identifies as necessary and/or appropriate for the target group.

DEVELOP BASIC MESSAGES FOR EACH OF THE CAMPAIGN THEMES

This is the step that often requires the most creativity and time. As discussed in the module, campaign messages which are positive and action-oriented are often more attractive and inspiring than those which demean men and/or focus only on negative consequences. Constructive examples include the Hora H campaign in Brazil, which promotes a "cool" and hip lifestyle based on caring and equitable attitudes. Another is the USA Strength Campaign, which emphasizes that a man's real strength is demonstrated through respect and compassion—and not through force or dominance.

MAP SOURCES OF INFLUENCE AND INFORMATION

This involves identifying and understanding the different sources of influence and information that shape male attitudes and behaviours related to gender, relationships and health. These can be groups of people such as peers and families; institutions such as schools, workplaces and health services; or media vehicles such as newspapers or TV. Again, this should come from information collected during the needs-assessment in addition to the input from men, boys and other stakeholders involved in the process.

DEFINE STRATEGIC MEDIA AND SOCIAL CHANNELS

Building on the profile and the mapping of the influences/information, the next step is to define which media (e.g. radio, magazines, billboards)

⁷ Taken from "Engaging Men at the Community Level", The ACQUIRE Project/EngenderHealth and Promundo, 2008.

and social (e.g. peer educators, local celebrities) channels would be the most strategic when it comes to reaching men and boys and/or secondary audiences with messages extolling positive models of masculinity and HIV prevention. It is important to also keep in mind how easy it will be for men and boys to access these different channels and the technical and financial feasibility of utilizing them for the campaign.

PRE-TEST WITH MEN AND BOYS AND SECONDARY AUDIENCES

This is the process by which campaign messages are confirmed as being clear, relevant ones that inform and/or mobilize men and boys as intended. Involving men and secondary audiences in the campaign development process helps to ensure the relevance and impact of those messages. Nevertheless it is still necessary to undertake extensive pre-testing to ensure that messages are widely understood. Pre-testing can be done through one-on-one interviews and/or focus groups with selected men from the target group itself. It is also important to pre-test messages with secondary stakeholders to ensure that they are acceptable and appropriate and will not generate backlash.

Campaigns:

Community Campaign Do's and Don'ts

DO

- Have convenient public spaces available for community discussions, men's education courses, or fundraisers.
- Guard the confidentiality of participants and contributors.
- Create a welcome and comfortable space with music, food, and magazines.
- Invite local leaders to attend.
- Involve men from the community in the creation, implementation, and evaluation of the campaign.
- Use images and short messages to target a lower-literacy audience.
- Attend regional and national conferences to support your campaign
- Conduct evaluation.

DON'T

- Require attendance.
- Assume men have or haven't heard the information before.
- Encourage participation by reinforcing traditional gender norms just to attract a larger group. Quality is above quantity.
- Produce expensive materials without conducting a needs assessment of what is needed and how to use them.
- Assume you know what the effects of the campaign will be.

Campaigns:

Door to Door Visits⁸

OBJECTIVE

To provide participants with the skills to make door-to-door visits in their communities

TIME

60 minutes

MATERIALS

Flipchart and markers

PROCEDURE

1. Ask if anyone in the group has experience making door-to-door visits (to sell a product, collect signatures, etc.). Ask them what that experience was like and how they prepared for it.

2. Ask participants to discuss the strengths and challenges of door to door visits. If the following hasn't been mentioned after five minutes, add it to the list:

BENEFITS

- Comfortable and familiar environment for the participant
- Convenient for the participant
- An opportunity to talk to a man and his partner

CHALLENGES

- Participants may be distracted by others at home (i.e. children, telephone, television)
- Participants may be wary of inviting someone into their home
- Peer educators must have some training before going out into the community

3. Door-to-door visits can be a low-cost way of reaching people in the community. Discuss the positive effects of interpersonal communication on behaviour change and how talking about gender or HIV prevention with someone visiting the home may provide community members with information they might otherwise be unable to access. Also, some community members may feel more comfortable talking about these issues in their homes than in a public setting.

4. It is important for group and peer educators to determine what areas and people in their communities would be most receptive to the information delivered in a door-to-door visit. It is also important to consider the best time of day for the visits. For example, if targeting young men, a peer educator must identify when young men are most likely to be at home. The educator needs to also think about whether the door-to-door visits are best made alone or with a partner. Finally, educators should discuss strategies for dealing with hostile community members who do not want to listen or who disagree with the messages; it is best to address a possibly negative situation before encountering it.

5. Ask for two pairs of volunteers and two groups of four to five volunteers. Take the two pairs out of the room and tell them that they will each role-play a door-to-door visit. The two groups of four to five volunteers will play the families: one group will be a friendly family that will listen and the other will be an unfriendly family with little time. One pair will be assigned to the friendly family and another to the unfriendly family. Ask the volunteers to make it as realistic as possible. Give the two groups of 4-5 volunteers, and the two pairs, 10 minutes to prepare and five minutes for each role play.

6. After both groups have completed the role-plays, ask them what it was like to conduct the door-to-door visits. What were the opportunities and the challenges?

7. Come back together as a large group. Ask the group for ideas on dealing with households that are receptive and unreceptive. Go over what they think they need to do to prepare for a door-to-door visit and list their ideas on a flipchart. If no one mentions it, be sure to suggest creating door-to-door visit scripts with ideas for dealing with receptive and unreceptive households. Stress the importance of practicing for both scenarios. Other strategies include: rescheduling another time for a visit and asking for a commitment to attend an event linked to your organization.

⁸ Adapted from "Engaging Men and Boys in Gender Transformation: The Group Education Manual", developed by EngenderHealth and Promundo for USAID



Sexual and Reproductive Health

Education: Checklist for positive gender-equitable sex education for boys and men⁹

- ✓ Sex education should begin early and continue throughout men's lives; be offered in different venues and focus on boys and men as their interests and needs evolve.
- ✓ Positive images of "sexy" men as loving, tender, and communicative need to be established and developed according to particular cultural settings: Media images of violent, dominant, exploitative male sexuality should be challenged and boys/men should be helped to critique these.
- ✓ Sexual wellness or sexual empowerment should be central to sex education. Girls/women and boys/men need to not only learn about their own bodies and sexuality, but also those of the opposite sex. They need to have the skills to act on that knowledge (including deciding not to have intercourse); and have sufficient agency to act on their values and to make sure their rights are respected.
- ✓ Support should be built into programmes to help boys and young men overcome fear of ridicule and rejection if they assume non-aggressive sexual attitudes and behaviours.
- ✓ Ways to enjoy the use of contraceptives should be emphasized; as well as the normative acceptance of their use within the wider community.
- ✓ Sex education should help boys and men analyze their values and to respect the values and rights of others.
- ✓ Promote care-giving and parenting skills and non-violent communication and negotiation skills among men and boys.

⁹ Adapted from "Engaging Men and Boys in Gender Transformation: The Group Education Manual", developed by EngenderHealth and Promundo for USAID

Education: Understanding Sexuality¹⁴

OBJECTIVES

1. To discuss human sexuality in a holistic and comprehensive way
2. To provide a framework for further discussions on sexuality and HIV

TIME

60 minutes

MATERIALS

- Flipchart
- Markers
- Tape
- Enough copies of Handouts 3: Definitions and Questions for Small Group Discussions about Sexuality and Handout 4: Definitions for Circles of Sexuality for all participants
- Resource Sheet 5: The Circles of Sexuality

ADVANCE PREPARATION

Prepare a flipchart with the circles of sexuality as illustrated in Resource Sheet 5: The Circles of Sexuality.

PROCEDURE

1. Explain that this session will explore the concept of "sexuality." Ask participants to share what they think sexuality means to them.
2. Explain that there are many long and complicated definitions of sexuality, but that they are often confusing. Tell them we like to simplify the definition, by thinking of sexuality as comprising several circles (see Resource Sheet 5: The Circles of Sexuality).
3. Draw the diagram by referring to Resource Sheet 5: The Circles of Sexuality. When drawing the circles, label each, but do not add the information shaded in grey in Resource Sheet 5. Each circle represents one of the elements of sexuality. When all of the circles are placed together, they encompass the total definition of sexuality. Explain that one of the circles is in a different color and is not linked to the others (Sexuality to Control Others) because it is a

negative element of sexuality, even if it exists in many situations.

4. Divide the participants into four groups. Explain that each will take on a sexuality circle and explore what they think it means (the Sexual Identity circle will be explained by the facilitator). Assign a circle to each group and ask them to describe what the circle entails using flipchart paper and markers. Pass out Handout 3: Definitions and Questions for Small Group Discussions about Sexuality and tell them to refer to the guiding questions related to their circle to help them with this activity.

5. Ask each group to present their four circles then explain the Circle of Sexual Identity. Once this has been done, pass out Handout 4: Definitions for Circles of Sexuality.

Make sure the key points of each circle are covered by referring to Handout 4.

6. After all of the circles are presented, conclude the activity with the following discussion questions:

- Is it easy to talk about sexuality? Why or why not?
- Are the challenges of talking about sexuality different for men and women? Why?
- What makes it hard for men to talk about this? What makes it hard for women?
- What would make it easier for men and women to talk about sexuality?
- Where is "sexual intercourse" included within the definition of sexuality? Does the term play a large or small role in the definition of sexuality?
- What are some similarities in how men and women experience sexuality?
- What are some differences? Why do you think these differences exist?
- What have you learned from this exercise? How can you apply this in your own lives and relationships?

¹⁴ Adapted from "Engaging Men and Boys in Gender Transformation: The Group Education Manual", developed by EngenderHealth and Promundo for USAID.

CLOSING

Sexuality is an important component of human life and while the sexual act for reproduction is similar for nearly all living creatures, only humans attribute values, customs, and meanings to sexuality that go beyond procreation. Sexuality also includes how we feel about our bodies, how we give and receive pleasure, and how we express romantic feelings, among other things. Unfortunately, in many cultures, men and women receive different messages about sexuality. Male sexuality is seen as impulsive and uncontrollable while women's sexuality is seen as passive and controllable. These contrasting messages often have negative implications for how men and women relate to each other in intimate and sexual relationships. It is therefore important that both men and women have opportunities to comfortably talk about sexuality and develop skills to communicate about sexuality with partners.

Sexuality to control others – Unfortunately, many people use sexuality to violate someone else or to get something from another person.

- How do people try to use sex to control other people?
- How do the media try to use sex to control others?

Handout 3

DEFINITIONS AND QUESTIONS FOR SMALL GROUP DISCUSSIONS ABOUT SEXUALITY

Sensuality – Sensuality is how our bodies receive and give pleasure.

- What senses do our bodies use to receive and give pleasure?
- What types of activities involve pleasure?

Intimacy/relationships – Intimacy is the part of sexuality that deals with relationships.

- What is needed for a healthy relationship?
- Where do we learn how to love and care for a person?

Sexual health – Sexual health involves our behaviour related to producing children, enjoying sexual behaviours, and maintaining our sexual and reproductive organs.

- What sexual health issues do men and women face?

Resource Sheet: The Five Circles of Sexuality



Handout 4

DEFINITIONS FOR CIRCLES OF SEXUALITY

SENSUALITY

Sensuality is how our bodies derive pleasure. It is the part of our body that deals with the five senses: touch, sight, hearing, smell, and taste. Any of these senses, when enjoyed, can be sensual. Ask the participants to provide examples of how a person might enjoy each of the five senses in a sensual manner. The sexual response cycle is also part of our sensuality because it is the mechanism that enables us to enjoy and respond to sexual pleasure.

Our body image is part of our sensuality. Whether we feel attractive and proud of our bodies influences many aspects of our lives.

Our need to be touched and held by others in loving and caring ways is called skin hunger. Adolescents typically receive less touch from family members than do young children. Therefore, many teens satisfy their skin hunger through close physical contact with a peer. Fantasy is part of sensuality. Our brain gives us the capacity to fantasize about sexual behaviours and experiences, without having to act upon them.

INTIMACY/RELATIONSHIPS

Intimacy is the part of sexuality that deals with relationships. Our ability to love, trust, and care for others is based on our levels of intimacy. We learn about intimacy from relationships around us, particularly those within our families.

Emotional risk-taking is part of intimacy. In order to experience true intimacy with others, a person must open up and share feelings and personal information. We take a risk when we do this, but intimacy is not possible otherwise.

SEXUAL IDENTITY

Every individual has his or her own personal sexual identity. This can be divided into four main elements:

Biological sex is based on our physical status of being either male or female. Gender identity is how we feel about being male or female. Gender identity starts to form at around age two, when a little boy or girl realizes that he or she is different from the opposite sex. If a person

feels like he or she identifies with the opposite biological sex, he or she often considers himself or herself transgender. In the most extreme cases, a transgender person will have an operation to change his or her biological sex (often called gender "re-assignment" surgery) so that it can correspond to his or her gender identity.

Gender roles are society's expectations of us based on our biological sex. Ask the group to think about what behaviours we expect of men and what behaviours we expect of women. These expectations are gender roles. Sexual orientation is the final element of sexual identity. Sexual orientation refers to the biological sex that we are attracted to romantically. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is feminine or a woman is masculine, people often assume that these individuals are homosexual. Actually, they are expressing different gender roles. Their masculine or feminine behaviour has nothing to do with their sexual orientation. A gay man may be feminine, masculine, or neither. The same applies to heterosexual men. Also, a person may engage in same-sex behaviour and not consider himself or herself homosexual. For example, men in prison may have sex with other men but may consider themselves heterosexual.

SEXUAL HEALTH

Sexual health involves our behaviour related to producing children, enjoying sexual activities, and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and sexually transmitted infections (STIs) are part of our sexual health. Ask the group to identify as many aspects of sexual health as possible.

After discussing the four circles of sexuality, draw a fifth circle that is disconnected from the other four. This circle is a negative aspect of sexuality and can inhibit an individual from living a sexually healthy life. You can say that the circle can "cast a shadow" on the other four circles of sexuality. It is described as follows: Sexuality to control others – This element is not a healthy one. Unfortunately, many people use sexuality to violate someone else or get something from another person. Sexual violence is a clear example of sex being used to control somebody else. Even advertising often exploits sex in order to persuade people to buy products

Services: Men's Reproductive Health Wall¹¹

OBJECTIVES

1. To understand the range of reproductive health services that can be provided to men.
2. To examine the range of men's reproductive health services that would be a high priority in the participants' communities.
3. To examine the range of men's reproductive health services that can be implemented at the participants' facilities.
4. To examine ways to create linkages to men's reproductive health services that cannot be provided at the participants' facilities.

TIME

30 minutes

MATERIALS

Flipcharts, markers, and tape

ADVANCE PREPARATION

Write the question "What are men's reproductive health services?" at the top of four flipcharts, holding the flipcharts horizontally.

PROCEDURE

1. Tape the flipcharts together so that they form one long stretch of paper, and display them on a wall.
2. Distribute markers to the participants, and ask them to write whatever responses come to mind on the "graffiti wall". Encourage them to write as much as they wish and to include services that are not provided at their facilities. Allow 10 minutes for completion.
3. Conclude the activity by discussing the questions below.

DISCUSSION QUESTIONS

- Which male reproductive health services, if any, are offered at your facility, either on-site or through outreach activities? (Supplement the discussion with information you collected during your advance preparation)
- Which services does your facility provide that you had not considered to be men's reproductive health services?
- What ideas do you have about new men's reproductive health services that might be added to those already provided at your facility?
- What services seem to be particularly needed or of high priority in your community? Which seem to be of particularly low priority? Why?
- How would you facilitate access to the men's reproductive health services needed in your community that your facility does not provide?

¹¹ Adapted from "Men's Reproductive Health Curriculum" developed by Engender Health [For more information visit the Engender Health website: <http://www.engenderhealth.org/pubs/gender/mens-rh-curriculum.php>]

Services: Values Clarification Exercise for Health Professionals¹²

The following situations are based on case studies observed at clinics where males have been seen and/or served. They are intended to help you think about and discuss your beliefs and values with regards to working with young men and serving them in your family planning/reproductive health clinic.

The situations are ideal for discussion in small groups of 5–7 staff. Have each group assign a recorder who will record the group's discussion and report back to the large group. Make sure that the group identifies the different issues that emerge from the vignettes and their responses to them. Facilitation of the full group discussion might be most fruitful if conducted by an outside facilitator.

NOTE: Ideally, it would be best to recount experiences gleaned from your own country or region or adapt the ones here to better reflect your own community.

SITUATION I

A male sheepishly walks into the clinic. The receptionist is on the telephone so the male takes a seat in the waiting room. After fumbling through a couple of magazines for a few minutes he puts them down. The receptionist stays on the phone but does not acknowledge him. Other waiting female clients openly stare at him. Finally he gets up and starts to walk out. The receptionist looks up just as he is exiting.

SITUATION II

A man comes into the clinic with his girlfriend. They both come to the reception desk and the receptionist checks the woman in for her appointment. She also gives her some paperwork to complete before she will be called and asks her to take a seat. The male partner, within hearing of the receptionist stammers to his girlfriend, "ah, I guess I'll wait for you in the car." He then exits and the woman takes a seat in the waiting room.

SITUATION III

A woman comes into the clinic with her mother at the same time as a man and his female partner, both for a pre-natal exam. Both women check in and then are seated with their mother and partner respectively. When the first woman is called, her mother accompanies her to the exam room. When the next woman is called, her male partner gets up to accompany her to the exam room. Before entering the hallway, the nurse

intercepts the couple and says to the man, "oh, I am sorry, you will have to wait out here".

SITUATION IV

Over the last few days two girls have tested positive for Chlamydia. When inquiring about their partners for notification, one man's name has come up as the partner for both of the girls. As the nurse practitioner (NP) is making a phone call in the front reception area, she recognizes one of the girls who tested positive for Chlamydia approaching the front desk with a male. The NP overhears the girl say that she has brought her boyfriend "John Doe" to be tested and she recognizes his name as the one mentioned by both girls. The receptionist tells the couple to be seated and that she will call them when there is an opening. The NP motions the receptionist into the back hallway from the desk and says, "you can just go tell little missy and Mr. Doe that they can just haul his little promiscuous butt over to the County STD clinic, we don't need his business, he's given us enough already!"

SITUATION V

Your nurse practitioner has been with you for the last two years even though you are a small town clinic. Until now the longest any mid-level has stayed is six months. She is passionate about women's health and is enjoying small town life after having spent 10 years in the Title X clinic in a big Eastern city. She left there because she resented, "people trying to tell us how to do our job! We know how to serve women and do it better than anyone else!" She is a little upset because your clinic has received special initiative money to serve males, which she laments, "just takes service dollars away from the women who need us." On the other hand, she feels, "it is probably good to make males be responsible finally."

One day at the clinic, she comes to the lobby to escort a young girl back for an exam. She notices another couple seated in the lobby; the male is probably 20 or 21, while the girl appears to be 16 or 17. The NP is visibly upset and tells the girl to go on back to the exam room. She then motions to the receptionist and nodding toward the young man and girl says, "you make sure I see that young girl, maybe I can talk some sense into her. And I would really prefer that that 'perp' not sit in my waiting room."

¹² John Snow, Inc. Research and Training Institute, Denver, Colorado [303] 293-2405

Maternal, Newborn and Child Health

Education:

The Baby is Crying¹³

OBJECTIVE

To promote a discussion about the difficulties and conflicts of caring for children.

MATERIAL

A doll and Resource Sheet: Essential Care for Infants

TIME

1 hour

PROCEDURE

1. Invite all the participants to sit in a circle.
 2. Give the following instruction: let us imagine that this doll is a child.
 3. Ask the group: Is it a boy or a girl? What is his/her name?
 4. Inform them that the child is crying a lot.
 5. Ask the group to imitate the sound of a baby crying.
 6. Pass the doll to one of the participants and ask him to calm the child. The rest of the group continues crying.
 7. After two minutes, if the baby (the group) is no longer crying, ask the participant to pass the baby on to the next person and proceed in the same way.
 8. Afterward, open up the discussion, exploring the comments of the group and their doubts in relation to child care (if required, use the Resource Sheet).
- Planning tips/notes: The doll can be replaced by a ball or any other available object, for example, a balloon.

DISCUSSION QUESTIONS

- What did you feel when the baby would not stop crying?
- Have you gone through a situation like this in your own life?
- What did you think was wrong with the baby?
- Why do babies cry?
- What can we do to get them to stop crying?
- Is it easy to care for a baby?
- Do women have greater skills or abilities for caring for babies? Why?

CLOSING

The facilitator should conclude by stressing that child care is a less complex activity than we usually think, but more tiring and time-consuming than we often imagine. We learn to care for babies through practice, but it is important to discuss with those that have already experienced similar situations or consult specialist books on the subject.

¹³ Taken from the Programme H manual developed by four Latin American NGO's: Promundo (Rio de Janeiro, Brazil - coordination), ECOS (São Paulo, Brazil), Instituto PAPA! (Recife, Brazil), and Salud y Género (Mexico). For more information about Programme H see www.promundo.org.br

Resource Sheet:

Essential Care for Infants¹⁵

1. THE HYGIENE OF THE BABY

Daily hygiene is essential for the health and well-being of the baby, but goes far beyond that.

It provides an important opportunity for intimacy and communication, of strengthening the ties between father and child. It can be a moment of joy and pleasure for the child and for the father. Bathing will immediately become a daily routine, as, if there is no impediment to such, it should be repeated every day: a quick bath in a suitable place, with the water at the right temperature (warm) so that the child does not feel cold or hot, taking care that everything is carried out in perfect safety conditions.

2. TOUCHING

During the early stages of life, a baby's skin is one of its main sensory organs. Thus, just as it reacts with obvious displeasure to any type of skin irritation, the baby feels enormous pleasure when it is in contact with warm water, which reminds it of the security of the maternal womb, and when it recognizes the touch of its parents' hands all over its body. The baby's hygiene can become one of the most enjoyable moments of the day. It is the moment to talk with the baby, stimulate its reactions and emotive responses.

3. GIVING A BATH

Prepare all the necessary materials, placing them within easy reach. Check that the water is not too hot or too cold and that there are no drafts. Put water in the bath. The water should be warm. Check the temperature by using the elbow or the internal part of the forearm, where the skin is more sensitive. Don't test the water with the hands, which are accustomed to withstanding much higher temperatures. Cleaning the face and the head requires special care. To wash the face do not use soap, only warm water. Have everything you need within reach. Don't leave the baby alone in the bath for a second: it can drown in a few centimetres of water.

Choose a place with no wind drafts.

As a precaution, fill the bath first with cold water and then add the hot water, until you reach the ideal temperature; never put hot water with the baby in the bath.

4. CHANGING DIAPERS

Always wash your hands before and after changing diapers.

5.a DISPOSABLE DIAPERS

Open the fastener on the diaper, but do not remove it immediately as the baby frequently urinates at this very moment. Wait a few moments to see what happens.

Check if it is dirty. Lift up the baby's legs, securing them by the feet with a finger between the ankles; using a towel, wipe the faeces in the direction of the diaper.

With the legs still raised, place the paper towel used for wiping in the diaper, roll everything up under the baby's body. Remove and proceed with the task.

Clean the area covered by the diaper with cotton, wool, or a cloth moistened with warm water. Dry well, particularly in the folds of the skin, and apply a lotion or anti-chafing cream, but never apply talcum powder. Leave the baby without clothes for some minutes, so that it can kick its legs at will, while its bottom is exposed to the air and dries thoroughly. Open a clean diaper, raise the baby by the legs and slip the part with the fastener under the body as far as the waist. Separate the baby's legs and pass the front part of the diaper between them.

Stretch the diaper at waist level and check if it is positioned correctly. Take the tape on one side, stretch and fasten and then do the same with the other. When fastening, make sure it is not too tight or too loose.

5.b COTTON DIAPERS

Raise the baby's legs and place the already folded diaper under the body. The top part of the diaper should reach the baby's waist. Avoid the formation of wrinkles, folding the ends and stretching the diaper. Pass the front part of the diaper between the baby's legs and stretch as far as it will go, adjusting well between the thighs so that the urine does not leak out. With one of the hands, hold the front of the diaper securely, so that it does not become loose.

¹⁵ Source: Your Child: Caring for the Baby Manual. Vol 1, 2, 3, 4. Rio de Janeiro: Editora Globo, 1995

With the other, fold over the ends and fasten with a safety pin (or adhesive tape). Do the same with the other end and check that the diaper is not too loose or too tight.

6. CLEANING THE BOTTOM

For girls: Always wipe from the front to the back, otherwise you can take germs from the anus to the vulva and cause an infection. Do not clean inside the vulva.

For boys: Wipe with a damp cloth or paper towel the folds in the groin and the genital organs. If the baby is not circumcised, clean the penis without forcing the foreskin back. Do not forget also to wipe the scrotum which should be cleaned from the front to the back, holding the penis to one side with the fingers, if necessary.

Services:

Sample Letter to Invite Men to Pre-Natal Services

This letter can serve to alert a man to come with his wife or partner to an ante-natal check-up. It should be adapted to suit the circumstances but it is important to always include the date and time of the counselling session and to print the letter on clinic letterhead if available. This was adapted from a letter used by EngenderHealth.

Date: _____

To Mr.: _____

Our Health Centre believes that working through dialogue with the community is crucial not only to improve our integrated health care but to also increase uptake of services. It's also believed that, as a father, you can play a paramount role in the health of your partner (wife) and your children. It is therefore an honour to invite you to come with your partner (wife) to be involved in the educational and counselling session to be held in our health centre on the date of _____, 20____ at ____ o'clock.

With regards,

Dr./Sr./Ms./Mrs./Mr. _____
Head of the Health Center

Campaigns:

Promoting Men's Role in Safer Motherhood¹⁴

OBJECTIVE

To develop information, education, and communication (IEC) messages to engage men in safer motherhood

TIME

45 minutes

MATERIALS

Flipcharts, markers, and tape

ADVANCE PREPARATION

No advance preparation is needed.

PROCEDURE

1. Explain that in order to increase men's awareness of their role in preventing maternal death, many programmes create establish campaigns that reach out to male audiences. Inform the participants that they will have an opportunity to create such a campaign.
2. Divide the participants into groups of five or six participants, and give each group some flipcharts and markers. Ask the groups to develop a promotional tool for the role of men in safer motherhood. The tool could be a television commercial, a radio drama, a poster, or anything else that could be used to promote this issue. Tell them they will have 20 to 30 minutes.
3. After the groups have completed their task, ask them to present their campaigns to the larger group. Allow the participants to discuss each campaign and the messages it promotes.
4. Conclude the activity by discussing which of the campaigns would be the most appropriate for the communities served by the participants' facilities.

¹⁴ Taken from Men's Reproductive Health Curriculum developed by Engender Health.

[For more information visit the Engender Health website: <http://www.engenderhealth.org/pubs/gender/mens-rh-curriculum.php>

Fatherhood

Education:

You're Going To Be A Father¹⁶

OBJECTIVE

1. To examine household duties and gender stereotypes often associated with them
2. To discuss the benefits of men sharing in household responsibilities

TIME

1 hour

MATERIALS

- Paper
- Pens
- Scissors
- A small box
- Resource Sheet 25: Messages

FACILITATOR'S NOTES

Facilitators will need to create their own stories that reflect the realities and cultural contexts of the group. It is vital for facilitators to write the messages in their own handwriting to make the activity more "realistic". Messages can be adapted according to cultural context—providing that the same line of reasoning or storyline is maintained for each:

1. Persons in a long-lasting relationship in which the pregnancy is unplanned;
2. Persons in a one-night-stand situation who have friends in common and in which the pregnancy was not expected; and
3. A couple who wants to have a child and finds out they are going to have one.

ADVANCE PREPARATION

Should the group have difficulty reading, the facilitator can read out the messages to each group. This activity can also be applied with adults.

Before beginning write three messages in your own handwriting. Cut out the three messages, fold them and place them in a small box.

PROCEDURE

1. Divide the participants in three groups.
2. Hand out messages that you developed cut earlier to each group.
3. Instruct the groups to stage a short role-play, which covers at least three items: (a) the place where the message was delivered; (b) who delivered it? And; (c) the reaction of the person that received it.
4. Each small group should present its role-play to the rest of the group.
5. Open up the discussion, exploring the similarities and differences between the scenes.

DISCUSSION QUESTIONS

- How are the three situations similar? How are they different?
- Is there any difference between pregnancy that occurs within the context of a long-lasting relationship and one that occurs following occasional sex?
- What does it mean for a man to assume paternity? Is contributing financially enough?
- To be a father, do you need to be a husband? Why or why not?
- What have you learned in this activity? Have you learned anything that could be applied in your own life and relationships?

CLOSING

Men generally experience a variety of feelings and expectations in relation to becoming a father. Existing gender norms may influence many of these. Often, men may believe that to be a father means to be a provider—that is, to assume financial responsibility. However, being a father also means being a caregiver—participating in prenatal care, changing diapers, helping with homework, etc. It is important to remember that a man can, and should still be involved in care-giving even if he is not married or romantically involved with the mother.

¹⁶ Taken from the Programme H manual developed by four Latin American NGO's: Promundo (Rio de Janeiro, Brazil - coordination), ECOS (São Paulo, Brazil), Instituto PAPA! (Recife, Brazil), and Salud y Género (Mexico). For more information about Programme H see www.promundo.org.br

Education:

Men, Women, and Caregiving¹⁷

OBJECTIVES

1. To increase awareness about traditional gender divisions in caregiving
2. To promote men's increased participation in caregiving in their homes, relationships, and communities

TIME

90 minutes

MATERIALS

- Two empty boxes (e.g. shoe box)
- Cut-outs
- Photos or drawings of people, animals, plants, and other things men and women care for

PROCEDURE

PART I - 45 MINUTES

1. Prior to the session, the facilitator should prepare up to 10 images (drawn or cut out from newspapers or magazines) of babies, elderly persons, large and small animals, plants, houses, cars, clothing, diapers, garden tools, and other persons/objects that men and women "care" for. If possible, the facilitator can bring some of the objects to the session themselves. It is okay to have multiple copies of certain images or objects. When working with school groups, cut-outs can be replaced with words, but the use of images, even in these groups, makes the activity richer.
2. At the beginning of the session, present the two boxes to the participants, saying that one of the boxes will be given to a man and the other to a woman.
3. Present the images and objects to the participants and ask them to place the images and objects that women know how to care for, or are better at caring for, than men.
4. In the man's box, ask the participants to put the images and objects that men know how to care for, or are better at caring for, than women.
5. After they have done this, take the images and objects out of the box, one by one, showing them to the group.

6. Then, try to explore how the men grouped the images and objects together, using the following questions:

- Why are some types of images and objects found only in the man's box?
- Why are some types of images and objects found only in the woman's box?
- Why do some images and objects appear in both boxes?
- Looking at the images and objects in the box for women, do you think that a man could properly care for these things?
- Looking at the images and objects in the box for men, do you think that a woman could properly care for these things?

PART II - 45 MINUTES

1. Write the words "female carer" and "male protector" on flipchart paper. Ask participants what the differences are between being a "carer" and being a "protector."
2. Ask participants what they know about the burden of AIDS care carried by women.
3. Make the point that AIDS makes it more important than ever that men share the burden of care.
4. Explain that you want to look at the pressures that prevent men from getting more involved in caring for others. Divide participants into three groups. Ask the first group to discuss the social pressures that make it hard for men to take on the role of "carer."

¹⁷ Taken from Engaging Men and Boys in Gender Transformation: The Group Education Manual, The ACQUIRE Project/EngenderHealth and Promundo, 2008

Education:

Division of Labor and Childcare in the Home¹⁸

OBJECTIVE

1. To examine household duties and gender stereotypes often associated with them
2. To discuss the benefits of men sharing in household responsibilities

TIME

45 minutes – 1 hour

MATERIALS

- Flipchart
- Markers
- Paper
- Pencils and pens

PROCEDURE

1. Ask participants to name typical household duties that take place on a regular basis. To assist, ask them to think about what needs to be done in a household from the first activities of the day until the last thing before going to sleep. List all of the activities on a flip chart, placing a number (beginning at 1) next to each activity as you go. The list of activities should include some of the following:

- cooking
- upkeep and maintenance including repairing household items
- shopping for food, clothes and household items
- cleaning and washing
- childcare
- eldercare
- safety
- school-related activities (transportation, homework, meetings at school etc.)
- paying the bills
- Feel free to add these to the list if participants do not mention them.

2. Distribute blank sheets of paper to the group. Ask the participants to reflect on the list, and identify whether it is the woman, man or both who undertakes the activities listed. Participants can simply write "woman", "man", or "both" next to the corresponding number on their sheet.

3. Ask the participants to tally the number of activities that women, men, and both sexes normally do. Ask each participant to share their results and list the totals on a new flip chart.

4. Facilitate a discussion using the questions below.

DISCUSSION QUESTIONS

- Did the tally of activities done by women and men in the household surprise you? Why or why not?
- Was there a lot of variation among the tallies of different participants? Why do you think that is?
- What factors contribute to men not participating in childcare?
- Do you think the division of labour between men and women in the home is changing or remains the same? Why?
- How has the need to provide additional home-based care to family members living with HIV affected the division of household labour between men and women?
- What are some of the benefits that come from men playing an active role in household duties?
- What can be done to promote more equitable distribution of labour in households?
- What have you learned in this activity? Have you learned anything that could be applied in your own life and relationships?

CLOSING

If and how a father is involved in childcare is not linked exclusively to biological characteristics, but depends more on how men and women are raised and whether they are raised to believe that men can also take care of children. Although girls and women are frequently brought up from an early age to care for children, men can also learn to care for a child—and learn to do it well. Questioning gender roles is part of the process of challenging the gender inequities, which increase vulnerability to HIV/AIDS.

¹⁸ Taken from "Engaging Men and Boys in Gender Transformation: The Group Education Manual", The ACQUIRE Project/EngenderHealth and Promundo, 2008

HIV and AIDS Prevention, Care and Support

Services: Developing a Fact Sheet About Men and Boys and HIV Prevention

A fact sheet is an essential tool for any advocacy effort related to men and HIV prevention. It should include the "why" and "what" of the issue at hand and should be presented in a straightforward and easy-to-read style.

The "why" should include factual and compelling information on the role men and boys play in HIV prevention. This type of information can be gathered from local organizations working on HIV/AIDS Departments, Ministries of Health, Demographic and Health Surveys (www.measuredhs.com) and UNAIDS (www.unaids.org), among other sources.

The second component of the fact sheet, the "what" should outline concrete actions that can be taken to positively engage men and boys in HIV prevention. These should be adapted to both the target audience and the local context. It is also important to include websites and other information sources where individuals or organizations can learn more about men, boys and HIV.

Below is an example of a short fact sheet designed for health services administrators and professionals. The "why" describes how men's sexual and health-seeking behaviours put both themselves and women at risk. The "what" presents several concrete suggestions for promoting men-friendly health services.

Handout 5

FACT SHEET: MEN, HIV PREVENTION AND HEALTH SERVICES

Four compelling reasons to engage men and boys in HIV prevention activities¹⁸:

1. Male behaviours put women at risk

On average, men have more sexual partners than women. Also, HIV/AIDS is more easily transmitted sexually from a man to a woman than from a woman to a man. Thus, a man who is HIV positive is likely to infect more persons than a woman who is HIV positive.

2. Male behaviours put men at risk

Men are more likely than women to use alcohol and other substances, behaviours that increase their risk of HIV infection. Additionally, men and boys are often negligent about their wellbeing and are less likely than women to seek health care.

3. The issue of men who have sex with men (MSM) has been largely hidden.

Surveys from various parts of the world find that between 1 to 16 per cent of all men report having had sex with another man, regardless of whether they identify themselves as gay, bisexual, or heterosexual. For men who are gay, or who have sex with men, prejudice and stigmatization can lead them to practice their sexuality clandestinely and inhibit them from seeking out sexual health information and services, thus creating situations of extreme vulnerability to HIV.

4. Male-friendly health services are an important part of HIV prevention

Providing men-friendly health services is an important aspect of promoting access to and use of

HIV prevention information, methods and support. Unfortunately, many men avoid health services because they are not "gender-friendly." Below are some suggestions for making your health services more friendly and accessible to men:

- Decorate the waiting rooms in such a way as to be attractive to men. Avoid colours and decorative items that are considered specific to women and babies. Display posters of men engaging in health-promoting behaviours such as holding/feeding a baby or wearing a bike or motorcycle helmet.
- In the waiting and examination rooms display client-education materials that provide information on issues relevant to men and boys such as male genital self-examination.
- Train health workers to recognize how important it is to work with men and boys. Offer the opportunity to deconstruct their own gender beliefs and help them to understand how these beliefs affect their professional interactions with men and boys.
- Clearly announce the availability of services for men and boys in posters and promotional materials that are distributed in the community.
- Make condoms readily available. Display signs advertising "condoms available" (for sale or free) at the reception desk or another area where men are likely to view them. Stocking more than one brand of condom, if possible, helps reinforce that idea that the health services takes men's contraceptive and disease-protection seriously.
- Offer a flexible schedule of services, including evenings and weekends, to accommodate men and boys and their work and/or school schedules.

Services: Tips for Providing VCT (Voluntary Counseling and Testing)¹⁹

PRE -TEST COUNSELLING

- Discuss what HIV/AIDS are, how the HIV virus is transmitted, and what behaviours could lead to transmission.
- Explain how the HIV test is done. The man may be concerned that it will hurt or cause discomfort. Answer any questions he has about the test and its accuracy. Explain that the test's reliability depends on the last time he may have been exposed and that it can take up to three or even six months after exposure to HIV—the "window" period—for the virus to be detected by the test.
- Emphasize that the test is voluntary and confidential.
- Encourage the man to think about who he will turn to for support. Partners? Parents? Other family members? Religious leader? Trusted friends? Help him determine who would be most supportive and practice how to talk to these people about being HIV-positive.
- Encourage the man to speak with his partner(s) about counselling and testing.

IF THE RESULT IS NEGATIVE

- Acknowledge the man's feelings of relief. Explain that a negative result means that HIV was not detected but emphasize that he could still be at risk if he practices unsafe behaviours or if he has practiced unsafe behaviours in the last three months. Suggest that if he has engaged in any risky behaviours—unprotected sex, use of injecting drugs—in the last three months, he should return to confirm the results by taking another test in one to three months, depending on the date he may have been exposed to HIV.

- Reinforce any healthy behaviours he reported in the pre-test session—such as using condoms and being faithful to one partner—and help him develop a plan to change any risky behaviours and maintain his HIV-negative status.

- Refer the man, as necessary, for ongoing medical care, counselling, support, or development of life skills such as self-esteem, problem solving, and dealing with peer pressure.

IF THE RESULT IS POSITIVE

- It can be very difficult to tell a man that he has tested positive for HIV. Try to deliver the news in a caring but not overly emotional way. Give the man the hopeful message that a person with HIV can remain healthy for a long time if he practices positive living habits.
- Review what a positive test result means. Explain that he has the HIV infection, but that he probably has not yet developed AIDS — unless he appears with an opportunistic infection or other clinical signs that may suggest he has. Review the difference between HIV and AIDS.
- Allow the man to express his feelings. Give him as much time as necessary. He might be angry, depressed, or afraid. He might feel betrayed by his partner or refuse to accept the test result. Listen to him, offer empathy, and show that you care about what he is going through.
- Encourage the man to tell his status to any sexual partner(s) he has had and/or — if appropriate — to anyone with whom he shared a needle. Acknowledge his fears about doing so. Offer to role-play; try first acting as the man, so that he can learn how to explain his or her status. Then, allow the man to practice by pretending that you are the person he needs to tell.

¹⁹ SOURCE: Boswell and Baggeley 2002

Education: Living Positively – Digital Stories²⁰

OBJECTIVE

To hear stories from people living with HIV/AIDS (PLWHAs) regarding living positively with HIV

TIME

45 minutes

MATERIAL

- Flipchart
- Markers
- EngenderHealth/South Africa MAP Digital Stories DVD;
- DVD player and Sound system

FACILITATOR'S NOTES

Before facilitating this session with the digital stories, be sure to view the stories yourself so you are familiar with the content. You also should review discussion questions, as well as key messages the storytellers are conveying.

If you do not have a copy of the digital stories, they are available on-line at www.engenderhealth.org

There are additional MAP digital stories focusing on living positively with HIV. Be sure to review Azola's, Thami's, and Msekeli's stories to see if they may be more appropriate for your audience.

PROCEDURE

1. Open this session by explaining that you would like to share two digital stories about men who are living positively with HIV. These men have chosen to disclose their status in the hopes of reducing stigma and encouraging others to get tested and cope with their infections. Explain that the stories are about 3 minutes long—and there will be short discussion after each of them.
2. Start by sharing Jason's Story. Once it has ended, conduct a discussion with the following questions, and conclude with the key points Jason is making in his story.

DISCUSSION QUESTIONS FOR JASON'S STORY

- What do you think Jason is saying in his story?
- How did Jason's story make you feel?
- Why do you think Jason felt ashamed?
- Have you ever felt isolated, alone or rejected?
- What did you do to get over those feelings?
- Why do you think people with HIV/AIDS are so often stigmatized?
- What can you do to end the stigma against people living with HIV/AIDS? What can you do to support HIV prevention?

KEY POINTS FROM JASON'S STORY (REVIEW AFTER DISCUSSION)

- People living with HIV/AIDS suffer from immense discrimination and stigmatization, as well as self-hatred, anger, and frustration.
 - This discrimination is unfounded and needs to end.
 - PLWHAs do not need to be defined by HIV; they are simply people who are living with the virus. PLWHAs have the power to define their own lives.
3. Next, share Bonile's Story. Once complete, use the following questions and key points for discussion:

DISCUSSION QUESTIONS FOR BONILE'S STORY

- What is Bonile saying in his story?
- How did it make you feel when he said he hated women? Why do you think he felt this way? Have any of you felt like this before? How did you deal with it?
- Why do you think people gossip and judge PLWHAs?

20 Taken from Men as Partners: A Programme for Supplementing the Training of Life Skills Educators developed by Engender Health and The Planned Parenthood Association of South Africa. For more information visit the Engender Health website: www.engenderhealth.org/ia/www/mwmo.html

- What can you do to stop the gossip and judgments?
- What do you think Bonile means when he says that he's responsible now?
- Where can you go to get more informed about HIV and AIDS?

KEY POINTS FROM BONILE'S STORY (REVIEW AFTER DISCUSSION)

- Being hurt, disappointed and angry can really hold a person back (e.g. how Bonile hated women before). You do not grow and do not lead a happy life.
- Being hurt by one person (e.g. his girlfriend) does not translate into the feelings and actions of everyone. Bonile formed the opinion that all women were not to be trusted, which is a harmful gender stereotype.
- It is important to know all you can about HIV/AIDS, including how to protect yourself. Equally, it is important to know your HIV status—so get tested if you have not done so already. Ignorance can harm and kill people.
- Simply because a person is living with HIV/AIDS, does not mean that he/she cannot have healthy loving relationships, and achieve their dreams and goals in life.

CLOSING

As these stories illustrate, many people living with HIV and/or AIDS face tremendous stigma and discrimination. This stigma and discrimination has harmful consequences both for these individuals, their families and communities and it is important for it to end. PLWHAs should not be defined by the fact that they have HIV; they are simply people who are living with the virus. PLWHAs have the power to define their own lives and like anybody else, they aspire to having healthy, loving relationships and can achieve their dreams and goals. As individuals living in communities where HIV and AIDS is present, we need to know how to support those who are living with the virus and to help reduce stigma and discrimination.

Education:

Getting Tested for HIV²²

OBJECTIVE

To discuss the importance of HIV/AIDS counselling and testing and related benefits and challenges

TIME

60 minutes

MATERIALS

- Paper
- Scissors
- Markers
- Tape

ADVANCE PREPARATION

Prior to the session, gather information from local centres that specialize in voluntary counselling and testing (VCT) and, if possible, arrange for a staff person to participate in this session and/or for the men to visit the centre itself. It is also important to be aware of policies and services related to the provision of anti-retrovirals (ARV) for people living with HIV and AIDS.

PROCEDURE

1. Ask for two volunteers to do play the part of a man arriving at a health centre for an HIV test and the counsellor who will see him. Participants should decide what the scene will be like, the expression on the man's face, his behaviour, and the appearance of the counsellor. Explain that it takes a little while to obtain the results of an HIV test and that this is the man's first contact with the health centre. The counsellor should be friendly and establish a rapport with the man. When you think it is appropriate, stop the scene with a command (e.g., "Freeze!").

2. Then, discuss the following questions with the participants:

- What do you think made the man want to take the test?
- How long do you think it took him to decide to take the test?
- How do you think he will cope with the result?
- How is he feeling? Is he afraid? Confident? Why?

- Do you think his family or friends know what he has come to do?

3. After discussing these questions, ask two other pairs to role-play the same scene, but this time, they should begin just as the test result is given. Assign a positive result to one pair and a negative result to the other, and have each play the part of the counsellor giving the result and the young man reacting. Do not let the other participants know which pair will act out the positive and negative results.

4. Prompt the group with questions about the two role-plays:

- How did the man receive the news about being positive/negative?
- Who do you think the first person he talks to will be?
- Why do you think the result of the test was positive/negative?
- What is he thinking of doing now that he knows he has/does not have the virus?

5. Have the group discuss the realities of each of the role-plays.

6. Finally, ask for two more pairs to role-play what the future holds for the man who receives a positive result and for the young man who receives a negative result.

7. Afterwards, prompt group discussion with questions about the role-plays:

- What initiatives should HIV-positive/HIV-negative men take?
- What are their expectations for the future?

DISCUSSION QUESTIONS

Wrap-up the discussion with the questions below.

- Do people in your community know where they can go for HIV counselling and testing? Do they trust it will be done safely and anonymously?

²² Taken from Engaging Men and Boys in Gender Transformation: The Group Education Manual, The ACQUIRE Project/EngenderHealth and Promundo, 2008

- How do you think people are treated when they seek HIV counselling and testing?
- How do you think they should be treated?
- Do you think men are more or less likely than women to seek out HIV counselling and testing? Why?
- What do you think are the biggest factors that hinder men from seeking HIV counselling and testing?
- What can be done to address these factors?
- What should a man do if his test result is positive?
- What should a man do if his test result is negative?
- How can you encourage more men in your community to be tested?

CLOSING

Men are often less likely than women to seek health services, including counselling and testing for HIV, since they often see themselves as invulnerable to illness or risk, or may just want to "tough it out" when they are sick. However, as has been discussed, men face many risks, and HIV testing is an important part of taking care of themselves and their partners. It is important for men to know where in their community they can get these services and to seek them out, when appropriate. The participants should think together about how to support those men who test negative so that they continue to protect themselves. They should also consider how best to encourage those men who test positive to seek out appropriate services and protect themselves and their partners from re-infection.

TRAINING OPTIONS

Invite the group to develop a role-play showing the two men meeting and talking before and after they receive results.

Gender-Based Violence

Education:

Don't Stand by, Take Action²³

OBJECTIVES

1. To identify the roles that men can play as active bystanders in stopping male violence;
2. To identify the supports that will help men take on these roles as active bystanders

AUDIENCE

- Age: Youth or adults
- Sex: Men; Literacy: Medium
- Resources: Medium

TIME

75 minutes

MATERIAL

- Flipchart paper
- Markers
- Sufficient copies of Handout 6: What Men Can Do as Active Bystanders for all participants

FACILITATOR'S NOTES

Pay attention to participants' reactions to this activity. It may remind some people of experiences in their own lives—when they were a target of violence and bystanders did not do enough to stop the violence, or when they were a bystander and did not do enough to stop the violence. Remind participants that it is okay to step out of the activity to take care of themselves. Make yourself available at the end of the session if anyone needs support.

Be clear that the aim of this activity is not to make anyone feel guilty for failing to stop violence in the past. Rather, it is to look to the future and to see what more we can do to help stop the violence in our communities.

PROCEDURE

1. Introduce the idea of the "active bystander" – use Handout 6 if needed. Ask participants to share examples of people taking on the role of being an active bystander and ask:

- What did these active bystanders do?

- Why was it important that they took some form of action?

2. Ask the group why it is so important that men take more action as Active Bystanders in trying to stop men's violence.

3. Brainstorm with the group some of the things that men could do as active bystanders in their community to take action to stop the violence.

4. Explain that one of the challenges of men taking on the role of active bystander is that this role can get confused with the sexist idea that men are supposed to protect women. What problems do you see with the idea that men are supposed to protect women?

5. Brainstorm with the group some of the main reasons that men give for not being more active as a bystander in trying to stop men's violence.

6. Pass out Handout 6. Break the participants into smaller groups and assign each small group a scenario from Handout 6 to prepare as a short role-play. Each role play illustrates a conversation between a reluctant bystander and a friend who persuades them to become active and take action.

7. Run the role-plays and then debrief using these questions:

- In the role-plays, what worked well and what not so well to persuade the person to become an active bystander?
- How can we persuade more people to become active bystanders?
- What stops men from being more active as bystanders?
- What is needed to help men become more active as bystanders?

8. Ask participants to get back into their small groups and give each group one of the scenarios to discuss for 15 minutes.

9. Bring the groups back to share the highlights from their discussion and their answers to the questions.

²³ Taken from Engaging Men and Boys in Gender Transformation: The Group Education Manual, The ACQUIRE Project/EngenderHealth and Promundo, 2008

10. Summarize the discussion by highlighting the need for men to take action as Active Bystanders, the actions that men can take and the supports that men might need.

CLOSING

Violence occurs every day because many people prefer to ignore it or deny it, especially male violence against women. An active bystander is someone who chooses not to stand by and let the violence continue, but takes some form of action to help stop the violence. Reducing the level of violence in society will require many more men to step up as Active Bystanders. Men commit most violence and many men are more likely to listen to another man than they are to a woman. These two facts make it essential that more men get involved as Active Bystanders in order to intervene with other men to stop their violence. It is also important to mobilize men with power to think of themselves as Active Bystanders in the effort to end violence – government and community leaders, business leaders, and policy-makers. Taking action as an Active Bystander is often not easy, especially for men who are taking action to stop other men's violence. It is important for men to identify ways that they can support each other in their efforts to be more Active Bystanders.

Sexist gender norms expect men to be the protectors of women. One danger in the Active Bystander approach is that some men will think that their role as an Active Bystander is to protect women. But the male protector role only ends up reinforcing women's disempowerment, which is the goal of men's violence in the first place. A core principle of the Active Bystander approach is that it must strengthen rather than weaken the empowerment of those who are targeted by violence.

Handout 6*

WHAT MEN CAN DO AS ACTIVE BYSTANDERS

There are many ways that bystanders can prevent, interrupt, or intervene in abusive and violent behaviours, and the majority carry little or no risk of physical confrontation. Since these interventions are not always apparent to people,

work with men as Active Bystanders should introduce as many non-violent, non-threatening options as possible. A key element of the Active Bystander approach is facilitating a discussion of options that bystanders have in a variety of realistic scenarios.

Here are some examples of non-violent options for bystander actions:

- Talk to a friend who is verbally or physically abusive to his partner in a private, calm moment, rather than in public or directly after an abusive incident.
- Talk to a group of the perpetrator's friends and strategize a group intervention of some sort. (There is strength in numbers.)
- If you have witnessed a friend or colleague abusing a partner, talk to a group of the victim's friends and strategize a group response.
- If you are a school or college student, approach a trusted teacher, professor, social worker, or health professional. Tell them what you've observed and ask them to do something, or ask them to advise you on how you might proceed.

EXAMPLE

Reasons given for not being an Active Bystander

- "It's a private affair- it's not my business"
- "My friends will not take me seriously if I speak out against violence"
- "I may get hurt myself if I get involved"
- "That is the job of the police"

SCENARIO 1

BOYS WILL BE BOYS

You are walking down a street and see a group of male construction workers verbally harassing a woman.

Questions for group to discuss

- What can you do in this situation?
- What possible consequences may happen to you? To the woman? To the men?
- Could anything be done to prevent this situation?

SCENARIO 2

NEIGHBOURLINESS

Your neighbours are a married couple. You often hear your neighbours arguing with each other. One night, you are asleep and are woken up by the sounds of your female neighbour screaming as if she is being hurt, and her husband is shouting at her.

Questions for group to discuss

- What can you do in this situation?
- What possible consequences may happen to you? To the woman? To the man?
- Could anything be done to prevent this situation?

SCENARIO 3

PARTY

You are with some friends at a house party. One of your male friends is always talking about how he is always getting with the women. You have heard from other people that he doesn't always treat women with respect. You notice one of your female friends is very intoxicated and being sweet-talked by the same guy. You see them leaving the party and go outside.

Questions for group to discuss

- What can you do in this situation?
- What possible consequences may happen to you? To the woman? To the man?
- Could anything be done to prevent this situation?

SCENARIO 4

ACROSS THE STREET

You are at a friend's house watching television. You hear a woman's voice screaming for help. You and your friends run outside and see a man sexually assaulting a woman across the street. You are not sure if he has a weapon or not.

Questions for group to discuss

- What can you do in this situation?
- What possible consequences may happen to you? To the woman? To the man?
- Could anything be done to prevent this situation?

* Adapted from: Online Toolkit for Working with Men and Boys, Family Violence Prevention Fund, San Francisco, USA

Education:

What is Violence?²⁴

OBJECTIVE

To identify different types of violence that may occur in intimate relationships and communities

TIME

1 hour and 30 minutes

MATERIALS

- Flipchart paper
- Marker pens
- Resource Sheet: Case Studies on Violence and Resource Sheet: What is Gender-Based Violence?

FACILITATOR'S NOTES

Prior to the sessions on violence, it is important to research locally relevant information concerning violence, including existing laws and social supports for those who use and/or suffer from violence. It is also important to be prepared to refer a participant to the appropriate services if he reveals that he is suffering violence or abuse

- Explaining that this is not a support group, but that you can see anyone afterwards to tell them about any support services that you know about;
- Being aware of people's reactions and body language and reminding the group of the importance of people taking care of themselves—such as, it is ok to take a break;
- Explaining that keeping full confidentiality is usually very difficult and that participants who want to talk about their own experience but who do not want others outside the group to know about it, can choose to talk about the violence that “people like them” experience; and
- Challenging participants who try to deny or reduce the significance of violence, in particular violence against women and children.

The case studies included in the Resource Sheet depict diverse types of violence. These include: physical, sexual and emotional violence by men against women in intimate relationships (case studies # 1, 2 and 3); Physical violence between

men (case study #4) and; community-level, or institutional, violence against individuals and groups of people (case study #5). If necessary, you can make adaptations to these case studies or create new ones to address other types of violence that also occur in intimate relationships, families and/or communities.

PROCEDURE

PART 1 – WHAT DOES VIOLENCE MEAN TO US? (30 MINUTES)

1. Ask the group to sit in a circle and to think silently for a few moments about what violence means to them.

2. Invite each participant to share how violence effects them and what it means. Write the responses on flipchart paper.

3. Discuss some of the common points in their responses, as well as the unique points. Review the definitions of violence below and let participants know that there is often no clear or simple definition of violence and that in the second part of the exercise you are going to read a series of case studies to help them think about the different meanings and types of violence.

Physical violence: using physical force such as hitting, slapping, or pushing.

Emotional / Psychological violence: often the most difficult form of violence to identify. It may include humiliating, threatening, insulting, pressuring, and expressions jealousy or possessiveness such as the controlling of decisions and activities.

Sexual violence: pressuring or forcing someone to perform sexual acts (from kissing to sex) against their will or making sexual comments that make someone feel humiliated or uncomfortable. It does not matter.

PART 2 – DISCUSSION OF DIFFERENT TYPES OF VIOLENCE (1 HOUR)

4. Read each case study on violence and use the talking stick to facilitate a discussion with the questions following each case study.

5. After having read all of the cases, discuss the following questions.

²⁴ Taken from Engaging Men and Boys in Gender Transformation: The Group Education Manual, The ACQUIRE Project/EngenderHealth and Promundo, 2008

DISCUSSION QUESTIONS

- What kinds of violence most often occur in intimate relationships between men and women? What causes this violence? (Examples may include physical, emotional and/or sexual violence that men use against girlfriends or wives, as well as violence that women may use against their boyfriends or husbands.)
- What kinds of violence most often occur in families? What causes this violence? (Examples may include the parental of physical, emotional or sexual abuse of children or other types of violence between family members.)
- What kinds of violence most often occur outside relationships and families? What causes this violence? (Examples may include physical violence between men, gang or war-related violence, stranger rape and emotional violence or, stigma against certain individuals or groups in the community),
- Are there types of violence that are related to an individual's sex? What is the most common type of violence practiced against women? (See Resource Sheet 27 –What is Gender-based violence?) Against men?
- Are only men violent, or are women also violent? What is the most common type of violence that men use against others? What is the most common type of violence that women use against others?
- Does a person—man or woman—ever “deserve” to be hit or suffer some type of violence?
- What are the consequences of violence on individuals? On relationships? On communities?
- What are the consequences of violence in relation to HIV? Sexual violence and HIV transmission? Condom usage?
- What can you and other young men do to stop violence in your community?

CLOSING

At its most basic level, violence can be defined as the use of force (or the threat of force) by one individual against another. Violence is often used as a way to control another person, to have power over them. It happens all over the world and often stems from the way that individuals—especially men—are brought up to deal with anger and conflict. It is commonly assumed that violence is a “natural” or “normal” part of being a man. However, violence is a learned behaviour and in that sense, it can be unlearned and avoided. As has been discussed in other sessions, men are often socialized to repress their emotions, and anger is sometimes one of the few socially acceptable ways for men to express their feelings. Moreover, men are sometimes raised to believe that they have the “right” to expect certain things from women (domestic tasks or sex, for example), and the right to use physical or verbal abuse if women do not provide these things. Men may also resort to violence to assert their views or decisions thereby making communication among partners about condom-usage, sex, and HIV almost impossible. It is important to think about how these rigid gender roles regarding how men express their emotions and how they should interact with women are harmful to both to individual men and to our relationships. In your daily lives, it is fundamental that you, as men, think about what you can do to speak out against other men's use of violence.

LINKS

This activity can also be linked to the earlier one on “Expressing my Emotions” and a discussion about how to handle anger.

Resource Sheet:

Case Studies on Violence and Resource

Case Study 1

Mtitu and Latifa are married. Mtitu's family is coming over to their home for dinner. He is very anxious that they should have a good time, and he wants to show that his wife is a great cook. But when he gets home that night, nothing is prepared. Latifa is not feeling well, and she has not made dinner. Mtitu is very upset. He does not want his family to think that he cannot control his wife. They begin to argue and yell at each other. The fight quickly escalates, and Mtitu hits her.

- Do you think that Mtitu was right to hit Latifa?
- How should Latifa react?
- Could Mtitu have reacted differently in this situation?

Case Study 2

You are dancing with a group of friends at the disco. When you are about to leave, you see a couple (a man and woman, apparently boyfriend/girlfriend) arguing at the entrance. He curses her (calls her names) and asks her why she was flirting with another guy. She says: "I was not looking at him... and even if I was, aren't I with you?" He shouts at her again. Finally, she says: "You don't have the right to treat me like that." He calls her worthless and tells her to get out of his face—he can't stand to look at her. He then hits her, and she falls down. She screams at him, saying that he has no right to do that.

- What would you do? Would you leave? Would you say anything? Why or why not?
- Would it be different if it was a guy hitting another guy?
- What can you do in situations like this one? What are your options?
- What is our responsibility to prevent others from using violence?

Case Study 3

Michael is an older boy who comes from a wealthy family. He meets Pili one day on her way home from school and they chat a little. The next day, he meets up with her again and this continues until one day he tells Pili how much he likes her. They start to kiss and Michael starts touching Pili under her blouse. But, then Pili stops and says that she doesn't want to go anything further. Michael is furious. He tells her that he has spent lots of time with her and says: "What are my friends going to say?" He pressures her to get her to change her mind. First he tries to be seductive, then he begins yelling at her in frustration. Then he begins pulling at her forcefully, pushing her down. He even begins to violate her sexually though she keeps saying, "No, stop!"

- Is this a kind of violence? Why or why not?
- What do you think Michael should have done?
- What do you think Pili should have done?

Case Study 4

A group of friends go dancing. One of them, John, sees that some guy is staring at his girlfriend. John walks up to the guy and shoves him and a fight begins.

- Why did John react this way? Do you think that he was right to shove the other guy?
- How else could he have reacted?
- What should his friends have done?

Case Study 5

In many communities, people who are living with HIV are shunned. They are insulted. Sometimes their children are not allowed to go to school.

- Is this a type of violence?
- Do you think that this type of discrimination hurts people living with HIV/AIDS?
- What can be done to stop these types of things from happening?

Resource Sheet:

What is Gender-Based Violence?

In many settings, most laws and policies use "family violence" or "domestic violence" to indicate acts of violence against women and children by an intimate partner, usually a man. However, there has been an increasing shift toward the use of "gender-based violence" or "violence against women" to encompass the broad range acts of violence that women suffer from intimate partners, family members, and other individuals outside the family. These terms also draw focus to the fact that gender dynamics and norms are intricately tied to the use of violence against women (Velzeboer, 2003). Though gender-based violence can apply to both men and women, the UNFPA focus is on women and girls as they are overwhelmingly affected.

Below is a definition of gender-based violence and violence against women based on the United Nations General Assembly Declaration on the Elimination of Violence Against Women in 1994:

...any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women because of being

women and men because of being men, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

...shall be understood to encompass, but not be limited to the following:

a. Physical, sexual and psychological violence occurring in the family, including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation

b. Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution

c. Physical, sexual and psychological violence perpetrated or condoned by the State and institutions, wherever it occurs.

Education:

Snakes and Ladder Game²⁵

OBJECTIVE

Allow men to understand the role that men have in violence against women and understand the inequalities women face.

Allow men to think of actions they can take to prevent violence against women.

TIME

1 hour or more

OPTION 1

Play the game on a one x one metre board on which 4 to 8 persons can play. More or less 10 persons can be involved as an audience.

OPTION 2

Play the game on a five x five metre board. Participants can walk on this board while wearing various colours of caps to identify them as different pieces (players) on the board. Try to use dice that are proportionate to the size of the board. Fifty to sixty persons can participate (including players and audience) utilizing this option.

FACILITATOR'S NOTES

This game was developed for a South Asian context and the forms of violence included may not all be relevant for other contexts. It was originally adapted from a popular board game, Chutes (slides) and Ladders, in which participants can progress by moving up the board via ladders or slide down if they encounter Chutes—in this case Snakes. The snakes represent the actions that men take that can cause violence against women or that support violence and gender inequality. The ladders represent what men can do to prevent violence against women and support gender equality. The game can be adapted to different realities by involving youth groups or others in formulating messages related to gender based violence and/or HIV (or other issues) and incorporating them into the game.

PROCEDURE

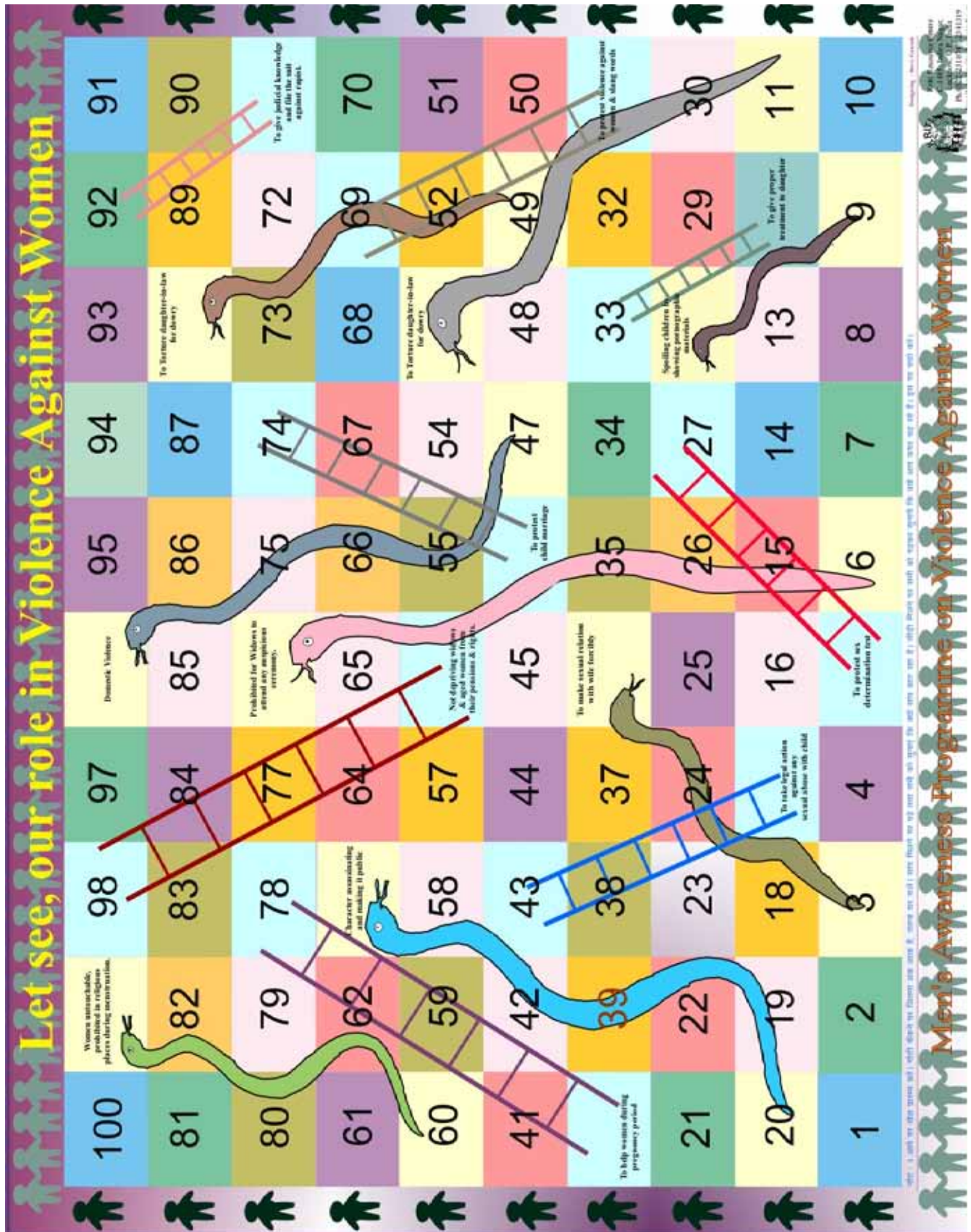
1. Participants throw the dice on the board and get the numbers.
2. The players who gets a number 6 can start the game and the rest of the order is based on the numbers participants rolled on the dice 3.
3. Each player rolls the dice when it is his turn to go. The players then move their symbols or themselves if they are walking on the board according to the number on the dice.
4. When they reach the point of a ladder or snake, the moderator requests that the audience loudly read the sentence written on the board and then to embark on a discussion utilizing the questions below.

QUESTIONS

- Who has been discriminated or violated by this particular behaviour?
 - Who is affected by this behaviour?
 - Who is responsible for this behaviour?
 - Is it common in our region/area/community?
 - Should it be continued?
 - If not, then who will take the responsibility?
 - Why should this player be demoted or promoted?
 - When the audience understands the issue and are convinced, the moderator will allow the participant to get a promotion (ladder) or demotion (snake) with permission of the audience.
5. The person who first reaches the end of the board (square 100) will win. The moderator will wait until all participants get to 100 and then declare 1st, 2nd and 3rd positions.

The moderator concludes the game with some individual development plans or pledges relating to stopping violence against women and girls. The moderator should also raise the issue of how patriarchal systems can harm men and boys

²⁵ This activity was created by MASVAW, a non-governmental organization from India - 'By Kriti Resource Centre, Uttar Pradesh, India' - NEED CORRECT REFERENCE



Education:

Violence against Women in Daily Life²⁶

OBJECTIVE

1. Better understand the many ways in which women's (and men's) lives are limited by male violence and/or the threat of men's violence, especially sexual violence.
2. Identify some actions they can take to prevent violence against women

TIME

90 minutes

MATERIALS

- Newsprint
- Markers

PROCEDURE

1. Draw a line down the middle of a flip chart paper from top to bottom. On the one side draw a picture of a man and, on the other, a picture of a woman. Let the participants know that you want them to reflect on a question in silence for a moment. Tell them that you will give them plenty of time to share their answers once they have thought it over in silence.

Ask the question:

- What do you do on a daily basis to protect yourself from sexual violence?
- What do you lack in order to be able to protect yourself?

2. Ask the men in the group to share their answers to the questions. Most likely no one will identify having to do anything to protect himself. If a man does identify something, make sure he is serious before writing it down. Leave the column blank unless his answer is convincing. Point out that the column is empty or nearly empty because men don't usually even think about taking steps to protect themselves from sexual violence.

3. If there are women in the group, ask the same questions. If there are no women, ask the men to think of their wives, girlfriends, sisters, nieces, mothers and imagine what these women do on a daily basis to protect themselves from sexual violence.

4. Once you have captured ALL the ways in which women limit their lives to protect themselves from sexual violence, break the group into pairs and tell each pair to ask each other the following question— explain that each person will have five minutes to answer the question:

- What does it feel like to see all of the ways in which women have to limit their lives because of fear and experience of male violence?

5. Bring the pairs back together after 10 minutes and ask people to share their answers and their feelings. Allow plenty of time for this discussion as it can often be emotional. Then ask each pair to find two other pairs (to form groups of 6 people) and discuss the following questions (write these out on newsprint) for 15 minutes:

- How much did you already know about the impact of male violence on women's lives?
- What does it feel like to have not known much about it before?
- How do you think you were able to avoid not noticing what an impact male violence has on women's lives?
- How does male violence damage men's lives as well?
- What do you think you can do to change this situation and to create a world in which women don't live in fear of men's violence?

After 15 minutes, bring the small groups back together and ask each to report back on its discussion. Write down the groups' answers to the last question on the Action Chart. Sum up the discussion, making sure that all the key points are covered.

FACILITATOR'S NOTES

This activity is critical for setting and establishing a clear understanding of the extent and impact of male violence against women. Be sure to allow ample time! This activity works best in mixed gender workshops where the ratio of men to women is reasonably balanced. But it can be included in any workshop.

26 Taken from The One Man Can Manual developed by Sonke Gender Justice of South Africa. For more information visit the Sonke Gender Justice Website Health website: www.genderjustice.org.za

If men are defensive, make sure to look more closely at their reactions. Make it clear that you're not accusing anyone in the room of having created such a climate of fear. Remind the group that you are trying to show how common and how devastating violence against women is.

Some people have strong emotional reactions to this activity. These reactions can include anger, outrage, astonishment, shame, embarrassment, defensiveness— among others. As workshop participants show their feelings, let them know that their reaction is normal and appropriate. Many people are shocked and become angry when they learn about the extent and impact of violence against women.

Remind them that anger can be a powerful motivating force for change. Encourage them to identify ways to use their anger and outrage usefully to prevent violence and to promote gender equity and equality.

Be aware that some men may think that they need to protect women from violence.

If some men in the group say this, remind the group that it is important for each of us to be working to create a world of less violence. Men and women need to work together as allies in this effort. The danger of saying that it is up to men to protect women is that we take away women's power to protect themselves.

KEY POINTS

Sexual violence and the threat of violence is an everyday fact for women.

Sexual violence against women is a huge problem around the world and all sectors of society. This violence against women damages women's lives in many ways.

Because men do not live with the daily threat of sexual violence, they do not realize the extent to which it affects women. Men usually do not understand how actual and threatened sexual violence is such a regular feature of women's daily lives.

Men's lives are damaged too by sexual violence against women. It is men's sisters, mothers, daughters, cousins and colleagues who are targeted by this violence— women that men care about are being harmed by sexual violence everyday. Social acceptance of this violence against women gives men permission to discriminate against women and makes it harder for men to be vulnerable with their partners, wives and female friends.

Education:

Coaching Boys into Men²⁷

Athletic coaches play an extremely influential and unique role in the lives of young men, often serving as a parent or mentor to the boys they coach. Because of these special relationships, coaches are poised to positively influence how young men think and behave both on, and off, the field. From speeches to the team, practice sessions, or simply casual conversation, coaches have many opportunities to impart their philosophies to athletes. The curriculum is based on the concept of teachable moments or opportunities when players demonstrate negative or positive actions and which the coach can use to speak to them and emphasize positive behaviour. The following is one example of a teachable moment.

TEACHABLE MOMENT

FAIR PLAY

Your team has just won a match. Your players are cheering and feeling a little overexcited. A couple of your players notice a girl on the sidelines. She's wearing revealing clothing, and the players start calling out to her, laughing and making lewd comments and sexual gestures.

DEFENCE

Step in as soon as the inappropriate behaviour starts and stop what your players may view as innocent fun.

OFFENCE

- Explain that taunting people is degrading and that no one should be put down because of how they look or what they choose to wear.
- Explain that most people do not welcome that type of attention and that no one is impressed by that behaviour.
- Emphasize that as members of a team, they know how important it is to respect each other. Tell them that the same holds true in other areas of life, and they must always think about how their actions affect another person.
- Finally, let them know that the men you admire don't need to insult women to get their attention.

COACH'S NOTES

Rude and suggestive comments are disrespectful

27 Taken from Coaching Boys into Men (CBIM) created by Family Violence Prevention Fund. It engages athletic coaches through the Coaches Leadership Programme to help shape the attitudes and behaviours of young male athletes. For more information go to: http://www.endabuse.org/content/action_centre/detail/806

Services:

Domestic Violence Assessment Card²⁸

This card is to be used by health providers to help to screen for domestic violence among their patients.

Domestic Violence is a pattern of assaultive and coercive behaviours, including physical, sexual and psychological attacks that adults or adolescents use against their intimate partners. Without intervention, the violence usually escalates in both frequency and severity resulting in repeat visits to the healthcare system.

ASSESS ALL PATIENTS FOR DOMESTIC VIOLENCE

1. Talk to the patient alone in a safe, private environment

2. Ask simple, direct questions such as:

- Because violence is so common in many people's lives, I've begun to ask all my patients about it routinely.
- Are you in a relationship with a person who physically hurts or threatens you?
- Did someone cause these injuries? Who?

The best way to find out about domestic violence is to ask directly. But be aware of signs of domestic violence which may include:

- traumatic injury or sexual assault;
- suicide attempt, overdose;
- physical symptoms related to stress;
- vague complaints;
- problems or injuries during pregnancy;
- history inconsistent with injury;
- delay in seeking care or repeat visits.
- Evasive, reluctance to speak in front of partner;
- Overly protective or controlling partner.
- Physical injuries; unexplained multiple or old injuries.

TAKE A DOMESTIC VIOLENCE HISTORY:

- Past history of domestic violence, sexual assault;
- History of abuse to any children.

SEND IMPORTANT MESSAGES TO PATIENT (AVOID VICTIM BLAMING):

- You are not alone;
- You are not to blame;
- There is help available;
- You do not deserve to be treated this way.
- Are you afraid to go home?
- Have there been threats of homicide or suicide?

ASSES SAFETY:

- Are there weapons present?
- Can you stay with family or friends?
- Do you need access to a shelter?
- Do you want police intervention?

MAKE REFERRALS:

- Involve social worker if available;
- Provide list of shelters, resources, and hotline numbers;
- Refer to a Domestic Violence Hotline if there is one;
- Schedule follow-up appointment.

DOCUMENT FINDINGS

- Use the patient's own words regarding injury and abuse;
- Legibly document all injuries; use a body map;
- Take instant photographs of injuries.

²⁸ This assessment card for health providers is adapted from The Family Violence Prevention Fund. For more information visit the Family Violence Prevention Fund website:

Advocacy and Policy

Building Alliances

OBJECTIVES

1. To examine the possibilities, advantages, and challenges of building new alliances
2. To increase the effectiveness and reach of efforts to engage men in HIV prevention

TIME

90 minutes

MATERIALS

- Flipchart and markers
- Resource Sheet 3: Management of Partners/Alliances

PROCEDURE

1. General Reflections on Establishing New Partnerships (20 to 25 minutes):

The questions below are designed to help groups reflect on their expectations and the perceived benefits and obstacles of new partnerships. It might be interesting for the group to consider organizations or individuals with whom they think it might be particularly challenging to work, but with whom they'd still like to establish partnerships.

It is important to keep in mind that these questions are only the first step in a longer process. They should focus only on exploring feelings about possible new partnerships. More specific discussions about potential partners and next steps will come later. After the discussion questions, review Resource Sheet—Management of Partners/Alliances quickly with the group.

- How do you feel about working with other organizations in partnerships and alliances?
- What might be the benefits? What might be the challenges?
- Imagine working closely with people you haven't previously seen as allies.

- How do you feel about working with them?
- How do other organizations perceive our organization (or its constituent parts)?
- How do these perceptions act as obstacles to collaborations?

2. Success Stories (10 minutes): The questions below invite the group to reflect on past examples of successful partnerships and how they can learn from these to build new partnerships.

- How have you worked in the past to break down barriers in building new alliances and involving men and boys? What are some of the successes you have had?
- What resources, approaches, or past successes open up possibilities for expanding alliances? What can you offer?
- What can you learn?

3. Identify Potential Partners (20 to 25 minutes): The goal of this step is to brainstorm potential partners. Prior to the session, the facilitator should create a chart featuring the column headings below on several sheets of flipchart paper and invite the group to brainstorm one column at a time. The explanation of headings can help identify what fits into each column. The group should keep in mind that this is not the time to evaluate or debate the pros and cons of potential partners. This will be done during the next step.

Column headings:

- Potential partners
- Benefits/reasons for working together
- Barriers to working together
- Resources and ideas for overcoming barriers
- How working with the partner fits (or doesn't fit) with our priorities and strengths

Potential partners:

This can include a wide range of institutions and organizations, (e.g., men's organizations and service clubs dominated by men; women's organizations and service clubs dominated by women; faith-based institutions; community groups; corporations; trade unions and professional associations; schools; scouts, sports clubs, and other youth organizations; high-profile individuals; different levels of government; and non-governmental organizations).

Reasons for/benefits of working together:

This includes the reasons for, and benefits of, forming a partnership with a particular organization or group. For example, you may wish to work with one organization in order to make contact with another organization with which it's affiliated. In other cases, you might want to take advantage of the organization's weight in the community; perhaps it's the largest corporation in the area, the only university, etc.

Barriers to working together:

These are the potential obstacles to building a partnership with the specific organization or group.

Resources and ideas to overcome barriers:

These include practical resources and ideas for overcoming such barriers (e.g., personal connections, physical proximity).

4. Prioritizing (15 to 30 minutes): The facilitator should review the chart developed in Step 3 and invite the group to categorize the potential partners, according to the criteria below.

The A List: High potential for partnership. An organization or institution on this list is very important, and there are many benefits to working together. Any barriers are surmountable, and a partnership would fit into your mandate and priorities.

The B List: An organization on this list has some potential, but it's not solid in as many categories, or one category may seem daunting.

The C List: Working with these organizations may offer few benefits, or perhaps there are far too many insurmountable barriers.

5. An Action Plan (25 to 60 minutes): The questions below are designed to help the group develop an action plan. Initially, the group should focus on the organizations in the A List. These same questions can then be repeated with organizations on the B List.

- Are there specific initiatives, campaigns, issues in the community, or events with which you can approach this organization?
- Do you want to start with one group or approach several groups? In the latter case, do you want to develop separate initiatives or try to form a coalition? (Keep in mind that your organization will need to meet separately with each group.)
- How can you involve some of your traditional allies and partners in this initiative and what information do you need to share with them about what you are doing?
- Who will take responsibility for drafting a proposal or making the first contact?

Resource Sheet

Management of Partners/Alliances

Building alliances are a cornerstone to effective and sustainable community engagement. The collective voices of diverse organizations and stakeholders can help to draw greater attention from government, media, and the general public to the importance of working with men and contributing to a supportive environment for changing the gender norms that increase HIV vulnerability.

Alliances can be local, national, regional, or international and can include diverse organizations—from civil society groups and religious institutions to private sector and government. The first step to building an alliance is to identify organizations which would be particularly strategic to include in programme, community, and advocacy efforts related to men and prevention, including:

- Organizations which have access to men who are generally hard to reach (e.g., out-of-school or migrants groups);
- Organizations which offer services which are particularly attractive to men (e.g., athletic associations); and
- Organizations which have reach and influence with large numbers of men (e.g., labour unions, military)

Education:

Dealing with the Opposition²⁹

This activity can be done with activists, peer educators, and programme staff to prepare them to for making public presentations.

OBJECTIVE

To develop the skills necessary to deal effectively with opposition

TIME

60 minutes

MATERIALS

- Flipchart paper and markers
- Resource Sheet: Responding to Opposition and Criticism: Dealing With Disagreement
- Enough copies of Handout 7: Responding to the Opposition for all participants

ADVANCE PREPARATION

Before the session begins, write the following statements on note cards:

- The Bible says the man must be head of the household.
- In the old days, women knew their place and homes were peaceful places. I think we should return to the old days!
- Women are not as strong or intelligent as men; how can they be trusted to make decisions?
- A woman walking alone and improperly dressed is asking to be sexually harassed or violated.
- Our culture has roles for men and women – and men are supposed to be decision-makers. Why are you trying to upset our culture?
- Men and boys cannot show weakness. Men who cry are cowards. Why are you trying to turn our boys and men into sissies?
- We don't have the financial resources for such programmes.

PROCEDURE

1. Open the session by asking participants how they think people in their community

will respond to male engagement (ME) programmes—the notion that gender equality and gender norm transformation are required for better health outcomes? Then ask if they think that their community supports gender equality? Ask what kind of barriers they encounter when they work with gender or sexuality?

2. Ask them what arguments they encounter in their own work with gender and HIV prevention? Now ask them what the arguments would be against the ME programme?

Have a few participants share their thoughts with the large group, and record their responses on a flipchart.

3. Explain that, although not everyone will be supportive, it is important to gain as much support from as many community members as possible to ensure the impact and sustainability of community-engagement efforts. Explain that this session will help participants to respond to possible community opposition to the ME programme.

4. Start by emphasizing that advocacy efforts depend on convincing people to support a course of action, then review the first two paragraphs of the Resource Sheet Responding to Opposition and Criticism: Dealing With Disagreement.

- Ask the participants to identify some of the sources of opposition (i.e., why will people oppose and criticize the programme?). Make sure that the reasons on the resource sheet are included here, as you make a list on a flipchart.

- Highlight the strategies of dealing with opposition, using a PowerPoint or flipchart.

- Prepared earlier. As you mention each strategy, ask participants to explain what each one entails.

- Explain how a programme is defended, making sure to use KISS – Keep It Short and Simple.

5. Ask for nine volunteers who would like to practice defending the ME programme. Line up two rows of nine chairs across from each other. Ask for volunteers to sit in one row of chairs. Then ask for another nine volunteers to sit in the row facing them, to serve as "members

of the opposition to ME." Every member of the opposition should be facing one of the supporters, thus forming pairs. Hand out note cards with statements to the "opposition." Be sure they do not share what is written on their cards with anyone. If there are fewer than 18 people, ask for fewer volunteers for each side and distribute fewer cards.

ALTERNATIVE OPTION

If there are not so many participants, you can ask some volunteers (the ones to defend the programme) to sit in front in a row as per the number of questions you will distribute while the rest of the participants remain seated to form the opposition (the ones to ask the questions). Distribute the questions to the opposition members randomly. After each volunteer has answered their question and the question has been discussed by the audience, the volunteer should join the audience to become part of it. This continues until the last question is asked.

7. Next, explain that you will role-play a community meeting to discuss the ME programme. The object is to learn to defend the programme when community members argue against it. Each member of the "opposition" will take a turn reading a statement to his or her partner and the "supporter" will immediately respond. Review the strategies outlined on the last page of the resources section before beginning. Once the supporter in each pair has responded, ask all the participants if they can think of any other strategies or responses to help counter the statement. Once a few participants have shared their thoughts, move on to the next pair. Use the examples from Handout 7: Responding to the Opposition if they were not used in the role-play or discussion.

6. Keep moving down the row until all of the volunteer "opposition" and "supporters" have read their statements and defended the ME programme. Distribute Handout 7: Responding to the Opposition, explaining that the responses in the handout were either used by the group or introduced by the facilitator during the activity.

7. Ask all participants to return to their previous seats and close this session with the following questions:

- What did you notice happening in this session?
- How did it feel to be a "supporter" or an "opposition member"?

- What strategies are important when defending the ME programme?
- What skills, if any, did you develop from this exercise?

STRATEGIES

- Form networks with other organizations. Working as a group makes each member stronger.
- Think strategically. One influential leader can help persuade many. Before seeking to convince people who may disagree, concentrate on an opinion leader who is likely to be supportive. Use his or her support to convince others.
- Be prepared. Look ahead at who might object to the programme and what he or she may say. Consider whether past statements give a sense of what kind of information he or she may listen to. Prepare the message before meeting with the person.
- Pick a persuasive message. Different kinds of information convince different people. For example, a leader may be concerned that a new gender education programme will provide too much information about sexuality to youth, but will agree that youth need more help understanding and preventing HIV. In this case, emphasizing that the programme will prevent AIDS is more effective than giving general information. Focusing on those goals that people agree with will help build common ground.
- Speak in terms the audience understands. People working on gender and health programmes sometimes speak to the public using technical terms. Remember to use language that will be understandable to the audience.
- Know when (and when NOT) to be defensive. Sometimes, ignoring the statements of critics makes their opinions sound valid. When opponents use inaccurate information, prepare to answer them with statistics, anecdotes, and other information. Providing this information can give people a more sound basis for making their own decisions. It is equally important, however, to know when to back down. When advocates seem to be attacking a popular person or institution, the perception can seriously damage an advocacy agenda.
- Having a public "war of words" with a policy maker or a religious or traditional leader might attract attention to the cause, or it might ruin the effort. Think carefully about possible reactions before responding.

- Encourage open and respectful debate. Communication is essential in order to address the concerns of the public and the objections of the opposition. Participate in programmes where the programme or policy is being discussed. Ensure that all public meetings adhere to rules that encourage order.

- Look for other ways to reach goals. Sometimes, despite everyone's best efforts, advocates are unable to convince a policy maker whose support is critical to the success of the advocacy campaign. One influential opponent may be able to block a plan for a long time. This means that alternative strategies designed to bring the programme forward will need to be considered. For example, if a school headmaster refuses to allow a gender-focused peer education programme, advocates for the programme might ask another institution, like the local youth centre, to base the programme there instead.

DEFENDING YOUR PROGRAMME

Here are some strategies for when you are defending your programme:

1. Make your responses as short and simple as possible (Keep It Short and Simple – KISS).
2. Agree with the opposition when you can.
3. Use facts to support your statements.
4. Remain calm/neutral. You are trying to persuade others, stay in control.
5. Research, religion and culture and use them to favour your cause. Religious texts have different interpretations.

Handout 7

RESPONDING TO THE OPPOSITION

The following are possible responses to the opposition's arguments:

The Bible says the man must be head of the household.

The Bible makes several references to this subject that can be interpreted in various ways. However, it also teaches us to respect one another and defend each other's human rights. In today's society, it is necessary for both men and women to earn an income and make decisions.

In the old days, women knew their place and homes were peaceful places. I think we should return to the old days!

When everyone is treated fairly and given equal opportunity, then life will be peaceful. When one group (women, for example) is oppressed, we are all oppressed. As Martin Luther King, the African-American civil rights leader, said: "Injustice anywhere is a threat to justice everywhere." Gender equality is as good for men as it is for women because women can help men carry the burden of providing for the family.

Women are not as strong or intelligent as men. How can they be trusted to make decisions? Men and women are equally strong and intelligent, but throughout history, men have not allowed women to make decisions. It is time we changed our ways, for the health of our communities. Educate a woman and you educate a society!

A woman walking alone and dressed improperly is asking to be sexually assaulted.

No woman asks to be sexually assaulted. Rape, for example, is when one person uses force to have sex with someone. No one asks for that. We have no idea why a woman is walking alone or wearing what she is wearing. Why do we judge people so quickly? Why do we not say the same things about men?

Our culture has roles for men and women—and men are supposed to be decision-makers. Why are you trying to upset our culture?

I am not trying to upset culture; I am just trying to make our communities and families healthier. It has been proven that gender equality will lead to better health outcomes.

Men and boys cannot show weakness. Men who cry are cowards. Why are you trying to turn our boys and men into women?

When people hold in their emotions, they can explode at some point and become violent. This is one reason there are so many passion killings. It is very unhealthy for men and boys to hold in their emotions, yet our society tells them they must do so. I am advocating for healthy men, and that means they should be able to express their emotions.

We don't have the financial resources for such programmes.

These interventions are not expensive! I am asking to integrate gender consciousness into our programming—that is all. The health of our families and communities depends on it!

How to Prepare for Lobbying or Face-to-Face Meetings²⁹

INTRODUCTION

A face-to-face meeting with a targeted decision-maker (also known as "lobbying") is one of the most frequently used advocacy methods and is often the starting point for a series of activities.

Personal contact builds relationships with decision-makers—which can prove very useful. Try to set up a channel for regular contacts. It is important to choose the right time to meet with decision-makers. For example: when your issue is already on their agenda or most likely to be taken up—just prior to an important vote—or when they are able to take action in support of your advocacy. During the budget-setting process, for example, or during an annual meeting.

Try to imagine how the issue or problem looks from the decision-maker's point of view. Why should they support your advocacy objective? How can they benefit from taking the action you are requesting? This can be answered more easily if you have fully researched the 'target person' you are meeting.

Make realistic requests. Show the decision-maker that there is widespread support for your advocacy objective. Encourage allies to also lobby the same decision-maker, giving the same message. It is difficult for officials to ignore large numbers of advocates.

Do not be satisfied with vague expressions of support. Return to two basic questions:

- Does the decision-maker agree that things need to change?
- What are they willing to do to make change happen?

ADVANTAGES

- It shows the human face of the issue or problem to decision-makers, especially if people directly affected by the issue are involved.
- No need for literacy.
- Good for involving people at community level.
- It is an opportunity to express emotions and share personal experiences.
- It allows you to discuss the issue rather than just present your position.

DISADVANTAGES

- The message could fail to make an impact if the decision-maker takes a personal dislike to the messenger(s).
- A decision-maker with greater negotiating skills could make the meeting a waste of time, or could persuade you to agree to actions you later regret.

PREPARING FOR MEETINGS

STEP 1: KNOW YOUR TARGET

Analyse your target. The leader of the gender agency could be a good entry point through which to discuss integrating men and boys. Legislative actors, however, may make better contacts because they more directly effect legislative change. Heads of state institutions or ministries are the best targets for administrative or regulatory issues—for example, those relating to health care regulations or the judicial enforcement of statutes. Remember, you may not be able to arrange a meeting with the person directly responsible for policy and decision-making, but you can arrange meetings with

people who can influence that person or who assist in the policy formation.

STEP 2: FOCUS ON YOUR MESSAGE

Choose your main objective and develop a simple message that supports it:

- What you want to achieve
- Why you want to achieve it (the benefits of taking action, and/or the negative effects of doing nothing; evidence for the problem—statistics and anecdotes)
- How you propose to achieve it
- What action you want the target person to take.

Write a short position paper to hand out to the decision-maker. The purpose is to remind her/him of your points.

STEP 3: CHOOSE THE RIGHT MESSENGER

Often the messenger is as important as the message. If a friend arranged the meeting, ask them to attend the meeting with you. On the other hand, someone who is directly affected by the problem may be able to 'personalize' the issue and capture the decision-maker's attention. Make sure the messenger possesses appropriate negotiation skills and attitude. This will result in a more positive outcome.

STEP 4: PRACTICE

Rehearse your message with colleagues or friends in a proxy meeting. Ask someone to play the role of decision-maker and request she/he to ask difficult questions.

AFTER THE MEETING

Write to the person who you met, thanking him/her for the meeting (even if that person was not helpful), briefly repeating your key points and any supporting comments made by the target person, especially any promises to take action. Tell the target person what you plan to do next, promise to keep him/her informed, and express the hope that you will be able to work together on the issue in future.

Reference: Adapted from An Introduction to Advocacy by Ritu Sharma (SARA Project).

29 This activity was adapted Advocacy in Action Card 4: Lobbying or face-to-face meetings from the Advocacy in Action: A Toolkit to Support NGOs and CBOS Responding to HIV/AIDS. Published by the International HIV/AIDS Alliance. Developed in collaboration with the International Council of AIDS Service Organizations (ICASO).

Writing a Press Release³⁰

INTRODUCTION

NOTE: In some countries a 'press release' is a paid advertisement. This guide refers to press releases that are not paid for and that are sent to newspaper, magazine, radio and TV journalists in order to assist them to produce stories.

A press release (or news release) is the standard method of distributing a story to the media (it is also possible to telephone a journalist to suggest a story, if you are sure that it is an interesting story and that it cannot easily be distorted).

Using the mass media is also an information, education and communication (IEC) method. It only becomes an advocacy method when:

- The general public has been identified as an 'indirect target' who will go on to influence a direct target—for example, voters who will influence a minister;
- Influential people are the targets of the article or broadcast item—for example ministers reading a newspaper.

GENERAL AIMS OF A PRESS RELEASE

- Outline an organization's response to an event/action;
- Draw attention to an issue;
- Provide background information on an issue/event or action;
- Give advance notice of an event;
- Announce new campaigns and provide progress reports;
- Provide a report of a meeting;
- Report decisions taken by organizations/groups;
- Circulate speeches in advance.

Media organizations receive hundreds of press releases each day, most of which are never 'picked up'. In order to get the attention of the media, a press release needs to be newsworthy, well written and interesting.

ADVANTAGES

- It is a very public form of advocacy which can increase pressure on decision-makers to take action.
- You can offer your selection of facts and opinions.
- You can decide when to give the information.

DISADVANTAGES

- Journalists receive too many press releases, so yours will be thrown away if it is not interesting or if a big news story 'breaks'.
- Journalists can still distort your story, even if it is clear in a press release.
- A good press release requires a good level of literacy, and some understanding of how journalists operate.

CONTENT OF THE PRESS RELEASE

Write a simple and interesting headline—this immediately helps the journalist to understand what the story is about.

The first sentence should summarise the most important facts of the story, i.e.:

- Who is involved?
- What is happening?
- Where is it happening?
- When is it happening?
- Why is this happening?

The main section of the press release should then explain these points in further detail. This helps to persuade the journalist of the facts and importance of the subject, and why it is of interest.

30 Adapted from Advocacy in Action Card 7: Writing and using a press release from Advocacy in Action: A Toolkit to Support NGOs and CBOS Responding to HIV/AIDS Published by the International HIV/AIDS Alliance. Developed in collaboration with the International Council of AIDS Service Organizations (ICASO)

Quotes can often make a press release more interesting and appealing. This is because journalists may not have access to the relevant people, are on a tight deadline or because the event has already passed. Direct quotations from the experts or 'newsmakers' highlighted in the press release:

- Should express an opinion, fact, or be able to support the view expressed in your press release;
- Allow for strong opinions that would look like blatant 'editorializing' if included in the main body of the text;
- Offer a 'human dimension';
- Are more effective than indirect quotations.

NOTE: If quoting an individual make sure you secure her/his permission first.

STYLE

- Short sentences, maximum 20 words.
- Short paragraphs, maximum two to three sentences.
- Copy the format and story structure from a newspaper article (this will make it easier to adapt into a story).
- Use a good case study or anecdote as evidence to support your point of view.

PRESENTATION

- Use headed paper so that it looks official and professional.
- Make sure that it is well laid out and easy to read.
- Type it, using double spacing, on one side of the paper only.
- Include the date and the name of the organization.
- Provide a contact name, telephone and fax number, and e-mail address as available.
- Give an embargo time (the day/date/time when the journalists are allowed to use the information).

PHOTOGRAPHS

- Include photographs of key people, places or action mentioned in the press release if you have them.

NOTE: Once a press release has been written it should be distributed to selected journalists and press associations by fax or e-mail—you can telephone them to ask for these numbers/addresses. Once the journalists receive the press release they will consider whether to include the story in their media work. They may also contact you for further information.

How to write a letter to the editor³²

Letters to the editor are an important media tool. They are quick to write, relatively easy to get published, and are the most widely read section in the paper. Politicians and government agencies routinely clip and circulate letters to the editor as an indicator of what is important to their constituents.

Letters to the editor, while often 'reactive' to news already reported, can keep the story alive and the debate raging. Journalism is one of the rare professions in which controversy is good. Reporters get 'extra points' when their stories spark debate. A furious war on the letters-to-the-editor page warms the hearts of reporters and delights editors. Among other things, it means people are reading the paper.

Tips on Generating a Letter to the Editor — Remember Your C's

BE CURRENT

Responding to a recent article in the newspaper or to a very recent event is a great way to increase your odds of being published. Refer specifically to the article by using the name of the article and date, such as "In response to your recent article on child care "

You can do a search on the newspaper's website for recent articles, using search words such as 'gender or gender equality,' 'HIV,' 'women's rights,' 'men and health,' 'Men and HIV,' 'fatherhood or paternity,' 'violence,' and 'violence against women.' Another option besides searching a website is to collect newspapers for a few days before writing your letter, and then skim them looking for a 'hook' that you can hang your response on, even if it is a stretch

Stories that do not speak directly to engaging men or boys will still be very effective links. For example a story about crime and violence would be a great opportunity to write about male norms that support violence and the need to address these social determinants of violence. Also, important dates or holidays, such as Fathers Day can be an opportunity to write about the role of fathers and the need for them to participate more in childcare.

BE CLEAR AND CONCISE

Keep your letter short and to the point. Stick to one subject and check your grammar. After you have written your letter, read it out loud and listen to it. Have you made your point clear? Can you shorten your letter and still get your point across?

Most papers will not print letters that are more than 250 words, or two to three paragraphs in length. The shorter the letter, the better chance it will be published.

CONSTRUCT

Your letter using the EPIC format. See Box. Connect the Dots

Connect the dots between engaging men and boys and the greater world at large. Link your topic issues to other social justice issues, health care and how it affects other programmes such as those targeting women and girls. Be creative in connecting the dots to other issues in your newspaper.

BE CONTROVERSIAL

Feel free to question or challenge what others have said or done: Start your letter off with an opening sentence. Be sure to avoid personal attacks, however: An argument based on merit rather than emotion tends to sway opinion.

Coordinate Your Efforts

Encourage as many people in your group to send in letters to the editor at the same time. This will maximize your odds of getting published and emphasize the importance of the issue. Whether they print your letters or not, you are letting the paper know that the community cares about the issue you have highlighted.

BE CONTAGIOUS

Maximize your efforts by sending the letter to newspapers all over the country w. (If you are trying to get a letter published in a major newspaper, do not send it to other minor papers until you are sure they will not print it.)

CONTACT INFORMATION

Include your address, e-mail and a daytime and evening phone number. They won't print this information, but may use it to confirm that you indeed wrote that piece of art!

32 Adapted from The Activist Milestones—Developing the Skills to Become a Trained Citizen Activist by RESULTS at <http://www.results.org/website/article.asp?id=1355>

EPIC STANDS FOR:

E FOR ENGAGE YOUR AUDIENCE

Here, you want to get your listener's attention with a dramatic fact or short statement. Keep this opening statement to one sentence if possible.

P FOR STATE THE PROBLEM

Here you present causes of the problem you introduced in the first section. How widespread or serious is the problem?

I FOR INFORMING ABOUT SOLUTIONS

Here you inform the listener about a solution to the problem you just presented. Develop your solution by offering examples of how and where it has worked, why, whether it is cost-effective and how it has benefited the poorest. You could site a recent study or report or tell a first-person account of how the solution has impacted you or others you know.

C FOR THE CALL TO ACTION

Now that you've engaged your listener, presented the problem and informed them of a solution, what do you want them to do? Make the action something specific so that you will be able to follow up with them and find out whether or not they have taken it. Present the action in the form of a yes or no question.





Organizational Self-Evaluation: Men, boys and HIV programme design and Monitoring and Evaluation³³

Historically men and boys have not been recognized as important stakeholders in helping to overcome the underlying causes fuelling the HIV/AIDS epidemic. To date, the focus on men and boys has mostly been developed from a negative perception of their propensity for risk-taking behaviour, or as members of important vulnerable groups, such as men who have sex with men (MSM) or young men with limited access to life skills and services. While it is essential to focus on these groups, and justified given the specific nature of the HIV/AIDS epidemic in particular settings, it is also important to seek to reach all males in certain contexts and address their own specific needs in relation to HIV/AIDS. It is also necessary to recognize that many attitudes, values, and behaviours which

men and boys display are the results of the aforementioned socialization processes, which can undermine their ability to develop the awareness and tools to necessary to seek support and to challenge and change the sometimes negative and harmful perceptions of what it means to 'be a man'.

The questions below are designed to help assess whether your organization is able to design, monitor and evaluate HIV/AIDS programmes, which do not reinforce behaviours that put women and men at risk. These should instead address the needs of men and boys and them as key stakeholders in challenging gender inequalities, changing negative and harmful constructs of masculinity and strengthening the response to HIV/AIDS.

PROGRAMME DESIGN		Y	I	N	NR
A2.1	Does your organization have the capacity to apply a gender perspective in programme design, i.e. the ability to analyze the different situations, needs, opportunities and constraints of different groups of women and men in society?				
A2.2	Does your organization assess how gender inequalities create different types of vulnerabilities for women and men? Specifically, does your organization assess how constructs or perceptions of masculinity may increase vulnerability to HIV and AIDS among different groups of men and women?				
A2.3	Does your organization examine how constructs or perceptions of masculinity may influence power dynamics (the control and use of power) between men and women, between different groups of men, and between men and children?				
A2.4	Does your organization assess how constructs or perceptions of masculinity may restrict men and boys from developing health seeking behaviours, and may increase their vulnerability to HIV and AIDS?				
A2.5	Does your organization have the capacity to link its gender analysis to other causes that contribute to vulnerability to HIV and AIDS, such as migration, conflict, and social exclusion?				

³³ This activity was adapted from the Self-Assessment Checklist for Men, Boys, and HIV/AIDS developed by International Planned Parenthood Federation.

A2.6	Does your organization create awareness in men and boys on how gender inequality contributes to put them at risk of illness and disease, including HIV and AIDS?				
A2.7	Does your organization have the capacity to design HIV and AIDS programmes which mobilize men and boys to promote gender equality, empower women, and challenge inequitable constructs of masculinity?				
A2.8	Does your organization have the capacity to design programmes that work with men and boys to affect change at multiple levels, i.e. individual level, community, policy, and societal change as well?				
A2.9	Does your organization have the capacity to design programmes which address the specific needs of men and boys in relation to HIV and AIDS, including links with their sexual and reproductive health and rights?				
A2.10	Does your organization promote minimum standards of do no harm ³⁴ , and analyze how programmes may create unintended benefits or adverse consequences that unintentionally increase vulnerability for both women and men such as: <ul style="list-style-type: none"> • Reinforcing negative stereotypes • Exposing women and girls to potential violence • Stigma against men and women of different sexual orientations • Leaving men unequipped to deal with peer pressure and criticism, etc. 				
A2.11	Does your organization have the capacity to design programmes for men and boys that address human sexuality issues in a non-judgmental and non-stigmatizing way?				
A2.12	Does your organization actively promote linkages of its programmes with other stakeholders in the community who can support change, such as unions, sport associations, professional associations, the media, faith-based networks, etc.?				

³⁴ Interventions on HIV/AIDS with good intentions may have unwanted (often negative) consequences. As such, the 'Do no harm' principle states that before undertaking any action it is important to consider the possible harm from any intervention, and then prevent this harm

MONITORING AND EVALUATION		Y	I	N	NR
A2.13	Does your organization disaggregate (break up) data by age, sex and sub-groups in order to allow for ongoing analysis & improvements?				
A2.14	<p>Do your organization's chosen indicators assess a range of factors and strategies contributing to mobilizing men and boys in promoting gender equality and women's empowerment, including:</p> <ul style="list-style-type: none"> • Men's health and well-being • Understanding how gender norms and roles influence men's attitudes and values, including health seeking behaviour • Examining constructs of masculinity and power imbalances in decision-making • Men and women's sexuality and sexual rights • Masculinity and homophobia • Masculinity and violence against men, women and children • Masculinity and men's mental health (e.g. suicide) • Gender inequality, vulnerability, confidence and self-esteem • Access to services by men, women and children • Control of resources (e.g., land, labor, productive assets, homeownership) 				
A2.15	Does your organization develop the capacity and leadership of men and boys and other stakeholders, such women's groups, to monitor your programmes with men and boys?				
A2.16	Does your organization link its monitoring and evaluation indicators to relevant national goals, e.g. as those set by your national AIDS strategy?				
A2.17	Does your organization use its evaluation measures to advocate for addressing gaps or making necessary changes/adjustments in national goals, e.g. as those set by your national AIDS strategy?				

Health Facilities Staff Needs Assessment Questionnaire³⁵

CONTACT INFORMATION

NAME OF STAFF PERSON: _____

HEALTH FACILITY: _____

CONTACT: _____

POSITION: _____

E-MAIL: _____

TYPE OF HEALTH FACILITY: _____

Briefly describe the services offered by this health facility, especially the types of programmes it supports related to HIV and AIDS.

OVERALL

1. In your opinion, what would HIV/AIDS services that are gender sensitive (male friendly) look like? Do you feel that the services you offer for HIV/AIDS are gender sensitive? In what way?

Note: If respondent seems unclear about the definition of gender sensitive, provide the following:

"Gender-sensitive programmes or services take into account the differences between men and women. They often consider the social and cultural context of what it means to be male or female when determining how services are provided. For example, a gender-sensitive programme may use different outreach techniques to reach men."

2. To what extent does your facility engage in community outreach and HIV prevention?

3. In what way, if any, do your HIV/AIDS services address the needs of men?

4. Do you have specific programmes or policies to help engage men in HIV/AIDS prevention, care, treatment and support? If yes, please describe.

5. Do you have specific programmes or policies to help address differences between men and women in terms of HIV/AIDS prevention, care, treatment and support? If yes, please describe.

6. Do you have specific hours or sections of your hospital reserved for male reproductive health? Have staff received any specialized training that

enables them to work with male reproductive health? Have staff received training to engage men in reproductive health?

GENDER NORMS

1. Based on your experience at this facility and as a member of the community, what gender issues do you think are most relevant in your country in terms of HIV/AIDS?

(If respondent seems unclear about the definition of gender, provide the following definition: "Gender" refers to widely shared ideas and expectations concerning women and men. These include ideas about typically feminine/female and masculine/male characteristics and abilities and commonly-shared expectations about how women and men should behave in various situations.)

2. What has your experience revealed about gender norms in your country regarding HIV/AIDS? (If respondent seems unclear about the definition of male gender norms, provide the following definition: "Male gender norms" are defined as behaviours, beliefs, and attitudes of each sex that are deemed appropriate by a society. For example, some common male gender norms are that men should be strong and should not cry.)

3. How do you think male gender norms impact HIV?

4. In terms of HIV/AIDS, what male norms and behaviours do you think need to be especially addressed? Are programmes currently addressing them? To what extent? How effective are these programmes? How could they be strengthened?

5. What type of technical assistance would best enable health facilities in your country providing HIV/AIDS care to integrate male-engagement programming into their work?

³⁵ This activity was adapted from the Needs Assessment Package for Male Engagement Programming developed by Promundo and EngenderHealth for the ACQUIRE Project.

CHALLENGES

- What are the specific limitations or obstacles that your health facility faces when trying to increase male engagement in HIV and AIDS programmes?
- How have you overcome these problems?

ACCOMPLISHMENTS

- What successes has your health facility experienced in providing gender-sensitive HIV and AIDS programmes? In increasing male engagement?

COST-EFFICIENCY AND FINANCING

- What are the human and financial resources your facility dedicates to gender programming? To male-engagement programming?

LESSONS LEARNED AND CONCLUSIONS

- Have your facility's programmes on gender and/or male engagement been evaluated? If yes, what were the results of the evaluation?

FINAL COMMENTS

- Is there anything else you would like to add?

Sample Logical Framework

A logical framework is a useful tool for planning, monitoring and evaluating projects. It presents key information about the project (e.g. goals, activities, indicators) in a clear, concise, logical and systematic way. The framework should be completed in partnership with donors, beneficiaries and other stakeholders prior to the onset of any activities. It is important to keep in mind that the framework should not be set in concrete – it should be flexible to changes or adaptations that may be deemed necessary during the monitoring process or consultations with donors, beneficiaries and others throughout the life of the project.

The parts to a logical framework are:

- **Goal:** contribution of the project to a wider problem or situation.
- **Outcome:** change that occurs if the output is achieved – the effect.
- **Output:** specifically intended results from project activities.
- **Activity:** tasks necessary to achieve the output.
- **Indicators:** qualitative and quantitative ways of measuring whether the outputs, purpose and goal have been achieved.
- **Means of Verification:** how and from what sources of information each of the indicators will be confirmed.
- **Assumptions:** external factors on which the success of the project depends and which management has little control.
- Below is a sample logical framework related.

LOGICAL FRAMEWORK RESULTS FORMAT³⁵

Overall Goal:								
Outcome 1					Budget (Budget break-downs are presented by outcome rather than output)			
Output 1.1	Activities	Indicators	Means of Verification	Assumptions and risks	Yr 1	Yr 2	Yr 3	Total
Output 1.2	Activities	Indicators	Means of Verification	Assumptions and risks	Yr 1	Yr 2	Yr 3	Total

Overall Goal:								
Outcome 2					Budget (Budget break-downs are presented by outcome rather than output)			
Output 2.1	Activities	Indicators	Means of Verification	Assumptions and risks	Yr 1	Yr 2	Yr 3	Total
Output 2.2	Activities	Indicators	Means of Verification	Assumptions and risks	Yr 1	Yr 2	Yr 3	Total

The Gender-Equitable Men Scale (GEM Scale): Measuring attitudes toward gender norms³⁶

Horizons and Promundo developed the Gender-Equitable Men (GEM) Scale to measure attitudes toward manhood and gender norms. These relate to sexual and reproductive health (SRH) promotion and disease prevention, partner violence, sexual and intimate relationships—among other topics.

The original 35-item scale was validated with a representative sample of men aged 15–60 in three communities—two of which were low-income and one middle-income—in Rio de Janeiro. It was administered as part of a larger household survey which included questions addressing a number of variables that were theoretically related to gender-equitable norms, including socio-demographic status, relationship history, history of physical violence, and current safer sex behaviours.

Testing confirmed that the attitude questions held together, meaning that young men answered in fairly internally consistent ways. That is, a young man who said he tolerated or even supported violence against women was also likely to show non-equitable or male-dominant views on other questions, such as believing that taking care of children was exclusively a woman's responsibility. Moreover, young men's attitudes were highly correlated with self-reported use of violence against women, confirming that the ways young men answered the questions were correlated to how they say they act.

The GEM scale can be used both as a needs assessment tool as well as an evaluation instrument. The scale, however, is particularly useful because it can be applied to a large number of young men in a relatively short amount of time. It is, of course, not perfect and it does not capture much of the rich detail or nuances related to gender attitudes and norms, which can be explored in focus groups and in-depth individual interviews. However, when time and resources are scarce, the attitude questions can be a relatively fast way to obtain a general sense of whether the young men who participate in activities are changing in positive ways. And, by being able to apply the questions to a large number of young men, the data is quite useful with respect to influencing policymakers who are often interested in achieving large scale impact.

THE GEM SCALE

Below are the items for the GEM scale. These items must be adapted and tested to conform to the cultural context and target group with which they will be applied. Answer choices are: Agree, Partially Agree, and Do Not Agree and Do Not Know. Instructions on scoring procedures are described below.

Subscale 1: "Inequitable" Gender Norms

1. It is the man who decides what type of sex to have.
2. A woman's most important role is to take care of her home and cook for her family.
3. Men need sex more than women do.
4. You don't talk about sex, you just do it.
5. Women who carry condoms are 'easy'.
6. Changing diapers, giving the children a bath, and feeding the children are the mother's responsibility.
7. It is a woman's responsibility to avoid getting pregnant.
8. A man should have the final word about decisions in his home.
9. Men are always ready to have sex.
10. There are times when a woman deserves to be beaten.
11. A man needs other women, even if things with his wife are fine.
12. If someone insults me, I will defend my reputation, with force if I have to.
13. A woman should tolerate violence in order to keep her family together.
14. I would be outraged if my wife asked me to use a condom.
15. It is okay for a man to hit his wife if she won't have sex with him.

³⁶ Adapted from text written by Julie Pulerwitz, Barker and Pulerwitz 2008

16. I would never have a gay friend.

17. It disgusts me when I see a man acting like a woman.

SUBSCALE 2: “EQUITABLE” GENDER NORMS

18. A couple should decide together if they want to have children.

19. In my opinion, a woman can suggest using condoms just like a man can.

20. If a guy gets a woman pregnant, the child is the responsibility of both.

21. A man should know what his partner likes during sex.

22. It is important that a father is present in the lives of his children, even if he is no longer with the mother.

23. A man and a woman should decide together what type of contraceptive to use.

24. It is important to have a male friend that you can talk about your problems with.

Items that Were Dropped (But May Still be Relevant in Other Circumstances)

25. A man always deserves the respect of his wife and children.

26. If she wants, a woman can have more than one sexual partner.

27. If a woman cheats on a man, it is okay for him to hit her.

28. Men can take care of children just as well as women can.

29. Real men only have sex with women.

30. Above all, a man needs respect.

31. If a man sees another man beating a woman, he should stop it.

32. Women have the same right as men to study and to work outside of the house.

33. I think it is ridiculous for a boy to play with dolls.

34. If a man cheats on a woman, it is okay for her to hit him.

SCORING PROCEDURES FOR THE GENDER EQUITABLE MEN (GEM) SCALE

(1) High scores represent high support for gender equitable norms. For subscale 1, Agree would be scored as 1, Partially Agree as 2, and Do Not Agree as 3. A high score represents low support for non-equitable gender norms or, in other words, support for gender equitable norms. For subscale 2, the scores are reserved so that for all items a high score represents high support for gender equitable norms. Do Not Know answers are scored the same as partially agree.

(2) Scores for the Inequitable Norm and Equitable Norm subscales are calculated separately and then combined into the Gender Equitable Men Scale. Each subscale, based on the sufficient internal consistency reliability, can also be used separately, if desired. The Inequitable Norm Subscale was found to be more reliable than the Equitable subscale in certain circumstances.

The GEM Scale is calculated as follows:

(a) For Inequitable Norms, the possible minimum was 17 and the maximum was 51. For Equitable Norms, the possible minimum was 7 and the maximum was 21.

(b) Responses to each item in each subscale are summed. This gives the GEM Scale score.

(c) Respondents for whom more than one third of the scale items are not answered, if using the full scale, and one third of either subscale, if one subscale is being used, it should be dropped from the analysis. For respondents missing less than one third of the scale items, the missing items should be replaced (i.e. imputed) with the mean of the item across all respondents.

(3) The continuous GEM Scale scores can be used in analyses as is, or can be recoded into different formats for different types of analyses and interpretations. As one coding option, the continuous GEM Scale is trichotomized into 'high', 'moderate,' and 'low' support for equitable gender norms by splitting the scale into three equal parts. The range is based on thirds in the range of possible scores: for the GEM Scale, low equity is 1 – 23, moderate is 24 – 47, and high is 48 – 72. Typical analyses include testing associations between the GEM Scale and key variables such as condom use and partner violence, as well as comparisons of GEM Scale scores before and after an intervention.

Questions from WHO Violence Against Women Study on Gender Roles³⁷

In this community and elsewhere, people have different ideas about families and what is acceptable behaviour for men and women in the home. I am going to read you a list of statements, and I would like you to tell me whether you generally agree or disagree with the statement. There are no right or wrong answers.

A good wife obeys her husband even if she disagrees

- ☐ Agree
- ☐ Disagree
- ☐ Don't Know
- ☐ Refused/No Answer

Family problems should only be discussed with people in the family.

- ☐ Agree
- ☐ Disagree
- ☐ Don't Know
- ☐ Refused/No Answer

It is important for a man to show his wife/partner who is the boss.

- ☐ Agree
- ☐ Disagree
- ☐ Don't Know
- ☐ Refused/No Answer

A woman should be able to choose her own friends even if her husband disapproves.

- ☐ Agree
- ☐ Disagree
- ☐ Don't Know
- ☐ Refused/No Answer

It's a wife's obligation to have sex with her husband even if she doesn't feel like it.

- ☐ Agree
- ☐ Disagree
- ☐ Don't Know
- ☐ Refused/No Answer

If a man mistreats his wife, others outside of the family should intervene

- ☐ Agree
- ☐ Disagree
- ☐ Don't Know
- ☐ Refused/No Answer

³⁷ This activity was adapted from "Researching Violence Against Women" by WHO and PATH

Sample Focus Group Questions for Young Men

Location: _____
Date: _____
Time started: _____
Time ended: _____
Interviewer(s): _____
Number of Participants: _____ Men

INTRODUCTION

1. INTRODUCE FACILITATOR(S).

2. EXPLAIN TO THE FOCUS GROUP:

Ex: "We want help in understanding the attitudes of men and boys related to gender and violence..." "We will ask some questions and want you to feel comfortable to answer honestly..." "We are all from a non-profit organization working in this community and all your answers will be confidential. We will not give names of individuals. Participation in the discussion is completely voluntary and you do not have to answer any questions that you do not want to answer." Confirm that they are willing to participate in the group interviews.

DISCUSSION

Below are sets of sample questions that can be used to develop a focus group guide for exploring young men's attitudes and experiences related to a variety of topics in a given context. Depending on the purpose of the focus group you can mix questions from different themes. Also, many of these questions can be adapted for working with older men as well.

GENDER ROLES AND NORMS

- What does it mean to be a young man in your community? Are there certain expectations for how young men should act? Do young men have certain responsibilities?
- Do you think it is easy to be a young man? Explain.
- Who would say your role model has been of what it means to be a man? What makes that person a role model?
- When and how does a boy become a man? How does a young man acquire respect?

- What does it mean to be a man? a father? a husband?
- When you think about the guys you know at school or in your community, how would you compare yourself (in terms of how they treat women, or whether they participate in violence)?
- What does it mean to be a young woman? How are young women treated in your community? What kinds of problems do they face? How do they cope with these problems? Do you think it is easy to be a young woman?

GENERAL NEEDS OF YOUNG MEN

- What are the biggest problems you and other young men face in your community? What do you think are some solutions to these problems? Are there places where young men can find support for their problems?
- Do you feel adults/elders understand the problems of young men today? Are young men able to express their views and share problems with adults and elders?
- What can be done to increase understanding and cooperation between young men and adults/elders?

SCHOOL/EDUCATION

- How would you describe your school? Do schools today meet the needs of youth? Are young men treated differently from young women in your school? In what ways?
- What things are good about your schools? What things need to be improved? What would you do to improve your school?
- Does your school prepare you for work? In what ways?

SEXUAL NORMS AND RELATED BEHAVIOURS

- What does sex mean to young men?
- What is the average age that young men have sex for the first time?
- Do young men generally have many sexual partners? For example, how many different

partners on average do young men have in a month?

- Is it ok for a young woman to have as many partners as young men do? Why or why not?
- What does it mean for a young man to have a stable partner? What does it mean for a young man to have a casual partner? Do young men prefer stable or casual partners? Why?
- Are there young men in the community who have sex with other men? If yes, are they treated differently in anyway by other young men or adults? If no, do you think it is ok for young men to have sex with other men?
- Is it ok for a young man to ever say no to sex? If yes, in what situations? If no, why not?
- What do you think about situations where young women will date and or have sex with older men – sugar daddies – in exchange for gifts, money, etc.? Are young men also involved in these types of relationships with older women or men?
- Have you heard of ways to prevent getting pregnant? Whose responsibility is it to use these methods? Do young people use them?
- Is it ever ok for a man to force a woman to have sex with him? If yes, in what situations?

HIV/AIDS-RELATED ATTITUDES AND KNOWLEDGE

- Are young men aware of STIs and HIV/AIDS? Do young men know how to prevent it? Where do young men get this information about STIs and HIV/AIDS? Do you know where you can get tested for HIV? Where?
- Do you think the young men in your community worry about STIs or HIV/AIDS? Why or why not?
- Do young men engage in behaviours that place them at risk for HIV/AIDS? If yes, what type of behaviours? How do you think programmes and governments can encourage young men to practice safer sex?
- Do young men use condoms? If yes, where do they get condoms? If no, why do they not use condoms?
- In sexual relationships, who usually decides if the couple uses a condom?

- Do you know any adolescents or youth who have, or have died from, HIV/AIDS? Are/were these individuals treated differently by family, friends, teachers, etc? Where can they go for support with their problems?

VIOLENCE AND CONFLICT (GENERAL)

- Is violence a problem in your community? What kind of violence?
- Who causes the violence in your community? Are young people involved in this violence? Why do you think these individuals/groups cause this violence? Are there certain individuals or groups who are the target of this violence? Are young men victims of violence in your community?
- Do you feel safe in your community? If yes, what makes you feel safe? If no, what makes you feel unsafe?
- Have you ever been beaten up in school or in your neighborhood? (Have you ever been robbed, or victim of any other kind of violence? Probe. Have you ever been a victim of violence by police or soldiers, or rival groups?)
- In general, how do the police react to young men's violence?
- Are young men like yourselves involved in fights? Over what? How often?
- Have young men you know participated in riots or attacks against other persons?
- What about gangs? (Probe to see if there is a local equivalent of gangs) Are they around in your neighborhood? Have they ever approached you? How did you react? (Do you have any friends/siblings/family members who are in gangs?)
- Do young men in the community carry weapons? If yes, what type and why? Do a large number of young men carry weapons?
- Do young men in the community engage in criminal activities? If yes, what type of activities, what are the consequences?
- What do you think are some strategies to preventing violence and crime among young men?

VIOLENCE AGAINST WOMEN

- Is it ok for a young man to hit a woman? In what situations? In what way?
- Have you seen this kind of violence in your community? In what situations?
- Have you ever felt like you were so mad at a girlfriend/wife/partner that you thought you might hit her? (What happened?)
- What would you do if you saw a man using violence against a woman?

COMMUNITY PARTICIPATION/ ASPIRATIONS

- Do you feel youth have enough opportunities to participate in community decision-making? If yes, in what ways to they participate? If no, how can they increase their voices in the community?
- What are your hopes for the future? Where do you see yourself in five years? What will you be doing and what support do you need to accomplish these goals?

Nine Steps to Monitoring and Evaluation

The 'nine-step' framework on designing and executing monitoring and evaluation (M&E), by Community Development (World Bank) in partnership with Business for Social Responsibility:

1. LOGIC MODEL AND INDICATORS

After finalizing the logic model for planning and management purposes, associated indicators should be created in consultation with stakeholders to monitor achievement at every step of the project, from inputs and activities to outputs and outcomes. Indicators should be Specific, Measurable, Achievable, Relevant and Timely (SMART).

2. VALIDATE INDICATORS WITH STAKEHOLDERS

Developing indicators is a key opportunity for community participation. By providing input on the indicators, community members are not only made aware of, but more importantly provide input to, project design and objective setting. This process of vetting indicators helps build ownership and transparency.

3. CONDUCT BASELINE ASSESSMENT

An assessment of current conditions is necessary in order to create a baseline against which to measure progress over time. For example, one can only effectively gauge an increase in primary school enrolment over time if there is information on initial levels of enrolment at the beginning of the project.

4. SET TARGETS AND SCALE

After finalizing the list of indicators that will be measured to monitor progress, targets should be set for each indicator. Targets are the goals that you are aiming to achieve by a certain point in time.

5. MONITOR INPUTS, OUTPUTS AND OUTCOMES

A project's specific data collection cycle will depend on the timeline for its targets, though periodic data collection in line with a company or organisation's quarterly reporting efforts is a good way to integrate community development into business processes. Data collection should ideally be participatory. By involving the community in monitoring, stakeholders can keep abreast of progress and make suggestions for course corrections, while the project partners can benefit from increased support and buy-in as a result of such transparency.

6. CONSULT STAKEHOLDERS ON MONITORING RESULTS

By reporting performance data gathered through monitoring, a company can meet community expectations for transparency and continue the dialogue about project design, management and performance. Information that is developed from monitoring should be disclosed in a "culturally appropriate" form that is accessible to all external stakeholders (in the local language, perhaps recited on local radio or in community meetings instead of being presented exclusively in written form, etc.).

7. MAKE PROJECT ADJUSTMENTS

Engaging stakeholders through data collection and reporting will help project managers gain information on how projects should be adjusted to better ensure that goals are consistently being met. Once this information is brought to light, adjustments to the project should be made to

improve performance. This is an iterative cycle that should be repeated throughout a project's life.

8. EVALUATE PROJECT IMPACTS

Project evaluation occurs after a project has been completed. It is an analysis that helps to explain why the project did, or did not, produce particular results. Unlike monitoring, it is not used for ongoing management, but focuses on final outcomes. Evaluations can be large scale surveys executed by an external group with statistical and social science expertise, such as a university. Likewise, it can be a small-scale rapid assessment that uses participatory methods, such as group interviews and key informants as well as available data such as case studies. Evaluation can not only help clarify whether costs for a project were justified but also inform decisions on the design and management of future projects and serve as an accountability mechanism.

9. REPORT AND ENGAGE STAKEHOLDERS

A final step in M&E is to share information on project impacts with shareholders, communities and the public at large through multiple channels. Reporting should not be seen as an end in itself, but rather as an invitation to dialogue with external stakeholders. The company or organisation can use M&E to inform the public of project progress and learning, as well as to invite feedback on the company or organisation's wider community development efforts.

References

References

- Addis, M.E., & Mahalik, J.R. (2003). *Men, masculinity, and the contexts of help seeking*. *American Psychologist*, 58 (1): 5–14.
- Aggleton, P., & Warwick, I. (1998). *Young people, sexuality, and HIV and AIDS education*. In L. Sherr (Ed), *Young people and AIDS* (pp. 79–90). London: Routledge.
- Aguayo, F., & Sadler, M. (2006) *Gestión Adolescente y Dinámicas Familiares*. Centro Interdisciplinario de Estudios del Género, University of Santiago, Chile.
- Armstrong, B. (2003). *"The Young Men's Clinic: Addressing Men's Reproductive Health and Responsibilities."* *Perspectives on Sexual and Reproductive Health*. 35 (5): 220–225.
- Auvert B, Taljaard D, Lagarde E, Sobngwi–Tambekou J, Sitta R, Puren A. *Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial*. *PLoS Med*. 2005 Nov;2(11):e298. Erratum in: *PLoS Med*. 2006 May;3(5):e298.
- Bailey RC, Moses S, Parker CB, et al. *Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial*. *Lancet*. 2007 Feb 24;369(9562):643–56.
- Bandura, A. (1965). *Influence of Models' Reinforcement Contingencies on the Acquisition of Imitative Responses*. *Journal of Personality and Social Psychology*, 1: 589–595.
- Barker, G. (1998). Non-violent male in violent settings: An exploratory qualitative study of pro-social low income adolescent males in two Chicago (USA) neighborhoods. *Childhood: a global journal of child research*, Vol. 5, Number 4, November 1998. 437–461.
- Barker, G. (2000). *What about boys: A literature review on the health and development of adolescent boys*. Geneva: WHO.
- Barker, G. (2001). *Peace boys in a war zone: Identity and coping among adolescent men in a favela in Rio de Janeiro, Brazil*. Unpublished doctoral dissertation, Erikson Institute, Loyola University, Chicago.
- Barker, G., & Ricardo, C. (2005). *Young men and the construction of masculinity in sub Saharan Africa*. World Bank Social Development Papers, Washington, DC.
- Barker, G., Ricardo, C., & Nascimento, M. (2007). *Engaging men and boys in changing gender inequity in health: Evidence from programme interventions*. Geneva, WHO.
- Bennett, L., & Williams, O. (2001). Intervention program for men who batter. In C. Renzetti & J. Edleson (Eds.), *Sourcebook on violence against women* (pp. 261– 277). Thousand Oaks, CA: Sage.
- Bertolote, J.M., & Fleischmann, A. (2002). *A global perspective in the epidemiology of suicide*. *Suicidologi*, 2: 6–8.
- Björk, I. (2004). *The best place for mothers? Science– Careers, 9 January*. Available at: http://sciencecareers.sciencemag.org/career_magazine/previous_issues/articles/2004_01_09/noDOI.14192357014694576805.
- Blake, M., & Babalola, S. (2002). *Impact of a Male Motivation Campaign on Family Planning Ideation and Practice in Guinea*. Baltimore: Johns Hopkins University Bloomberg School of Public Health, Center for Communication Programs.
- Boler, T., & Aggleton, P. (2005). *Life skills-based education for HIV prevention a critical analysis*. London: ActionAid International and Save the Children.
- Burgess, A. (2007). *The costs and benefits of active fatherhood: evidence and insights to inform the development of policy and practice*. Fathers Direct.
- Burgess, A. (2008). *Maternal and infant health in the perinatal period: the father's role*. Abergavenny, UK: The Fatherhood Institute.
- Carter, M.W. (2002). *'Because He Loves Me': Husbands' Involvement in Maternal Health in*

Guatemala. Culture, Health & Sexuality, 4 (3): 259–279.

Canadian Public Health Association. (2005/2006). *Men, HIV and Home-based Care*. Canadian Public Health Association Health Digest, 29 (4): 8.

Carter, M.W., & Speizer, I. (2005). *Salvadoran fathers' attendance at prenatal care, delivery, and postpartum care*. Revista Panamericana de Salud Pública, 18 (3).

Clark, S., Bruce, J., & Dude, A. (2006). *Protecting young women from HIV/AIDS: the case against child and adolescent marriage*. Int Fam Plan Perspect. Jun;32(2):79–88.

Communication Impact (2003). *Men in Jordan Get Involved in "Together for a Happy Family."* Johns Hopkins Bloomberg School of Public Health Center for Communication Programs. Communication Impact, January, Number 14: 1–2.

Cunningham, A., Jaffe, P.G., Baker, L., Dick, T., Malla, S., Mazaheri, N., & Poisson, S. (1998). *Theory-Derived Explanations of Male Violence against Female Partners: Literature Update and Related Implications for Treatment and Evaluation*. London: London Family Court Clinic.

Davis, J., & Perkins, W. (1995). *Fathers Care: A Review of the Literature*. Philadelphia, PA: National Center on Fathers and Families, University of Pennsylvania.

Drennan, M. (1998). *Safe Motherhood and Child Development: How Men Can Help. Reproductive Health: New Perspectives on Men's Participation*. Population Reports, Series J, No. 46. Baltimore, Johns Hopkins School of Public Health, Population Information Program.

Esplen, E. (2009). *BRIDGE Overview Report on Gender and Care*, Brighton: IDS

Family Violence Prevention Fund (FVPF). *The Facts on Health Care and Domestic Violence*. Available at: http://www.endabuse.org/userfiles/file/Children_and_Families/HealthCare.pdf

Farquhar, C., Kiarie, J.N., Richardson, B.A., Kabura, M.N., John, F.N., Nduati, R.W., Mbori-Ngacha, D.A., & John-Stewart, G.C. (2004). *Antenatal couple counseling increases uptake of interventions to prevent HIV-1 transmission*. Journal of Acquired Immune Deficiency Syndromes, 37 (5): 1620–1626.

Fisher, D. (2007). *Including New Fathers: A Guide for Maternity Professionals*. UK: Fathers Direct.

Fisher, A.A., & Foreit, J.R. (2005). *Designing HIV/AIDS Intervention Studies – an operations research handbook*. New York: Population Council.

Flood, M. (2004). *Backlash: Angry men's movements*. In Rossi, S. (Ed.), *The battle and back-lash rage on: Why feminism cannot be obsolete*, 261–278. Philadelphia, PA: Xlibris Press.

García-Moreno, C., Jansen, H.A.F.M., Ellsberg, M., Heise, L., & Watts, C. (2005). *W.H.O. Multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Geneva: World Health Organization.

Garin, G.D. (2000). *Report No. #5702c*. Washington, DC: Peter D. Hart Research Associates, Inc.

Gray RH, Kigozi G, Serwadda D, et al. *Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial*. *Lancet*. 2007 Feb 24;369(9562):657–66.

Greene, Margaret E., Mehta, M., Pulerwitz, J., Wulf, D., Bankole, A., & Singh, S. (2006). *"Involving men in reproductive health: Contributions to development,"* background paper to the report Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. New York: UN Millennium Project.

Gondolf, E. W. (2002). *Batterer interventions systems: Issues, outcomes, and recommendations*. Thousand Oaks, CA: Sage.

Gupta, G.R. (2000). *Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How*. Washington, DC: International Center for Research on Women.

Gupta, G.R. (2002). *Vulnerability and Resilience: Gender and HIV/AIDS in Latin America and the Caribbean*. International Center for Research on Women (ICRW).

Guttmacher, (2003). *In their own right: addressing the sexual and reproductive health needs of men worldwide*. The Alan Guttmacher Institute . Available at: http://www.guttmacher.org/pubs/itor_intl.pdf

Hancock, J. (2004). *Can mainstream services learn from male only sexual health pilot projects?* Sexually Transmitted Infections 80: 484–487.

Hegg, M.O., Orozco, R.C., & Venerio, M.C. (2005). *Masculinidad y factores socioculturales asociados al comportamiento de los hombres: estudio en cuatro países de Centroamérica*. Mexico: Sede Subregional de CEPAL.

- Hewlett, B. (2005). *Are the men of the African Aka tribe the best fathers in the world?* The Guardian, 15 June. Retrieved at "[http://www.guardian.co.uk/society/2005/jun/15/ childrenservices.familyandrelationships](http://www.guardian.co.uk/society/2005/jun/15/childrenservices.familyandrelationships)".
- Horizons (2003). *How Implementing PMTCT Services Expands HIV Prevention and Care: Evaluation finds multiple benefits for facilities, clients*. Horizons Report. New York: Population Council.
- Horizons (2004). *Promoting Healthy Relationships and HIV/STI Prevention for Young Men: Positive Findings from an Intervention Study in Brazil*. Washington DC: Population Council/Horizons.
- Hudson, D., Campbell-Grossman, C., Fleck, M., Elek, S., & Shipman, A. (2003). *Effects of the new fathers network on first-time fathers' parenting self-efficacy and parenting satisfaction during the transition to parenthood. Issues in Comprehensive Pediatric Nursing*, 26 (4): 217–229.
- Hudspeth, J., Venter, W.D.F., Van Rie, A., Wing, J., & Feldman, C. (2004). *Access to and early outcomes of a public South African antiretroviral clinic*. The Southern African Journal of Epidemiology and Infection, 19(2): 48–51.
- Ingham, R., & Mayhew, S. (2006). *Research and policy in young people's sexual health. In Promoting Young People's Sexual Health; International Perspectives* (209–225) London: Routledge.
- Interagency Gender Working Group (2005). *Implementation guide on reaching men to improve reproductive and sexual health for all*. Available at the following URL: www.jhuccp.org/igwg/.
- International Labor Organization (2007). *Equality at work: tackling the challenges. Global report under the follow-up to the ILO Declaration on fundamental principles and rights at work: Report of the Director-General*. Geneva: International Labor Organization.
- Jewkes, R., Nduna, M., Levin, J., et al. (2008). *Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomized controlled trial*. BMJ, 337:1–11.
- JHUCCP (1997). *Reaching Men Worldwide: Lessons Learned from Family Planning and Communication Projects, 1986–1996*, Working Paper Series No. 3, Baltimore, MD.
- Kamal, I.T. (2002). *Field experiences in involving men in safe motherhood. In Report of the meeting of WHO Regional Advisors in Reproductive Health*. Geneva, Switzerland: World Health Organization.
- Kaufman, M. (2003). *The AIM Framework: Addressing and Involving Men and Boys To Promote Gender Equality and End Gender Discrimination and Violence*. New York: UNICEF.
- Kaufman, M. (2004). *'Transforming our interventions for gender equality by involving men and boys: A framework for analysis and action'*, in Ruxton S (ed), *Gender equality and men: Learning from practice*, Oxfam, Oxford.
- Kiernan, K., & Smith, K. (2003). *Unmarried parenthood: New insights from the millennium cohort study*. Population Trends, 114: 23–33.
- Kruger, V. (2003). *Being willing to love and support them: An EngenderHealth report on focus group discussions held in Soweto by the HOPEworldwide men as partners staff*. Johannesburg: EngenderHealth.
- Kunene, B., Beksinska, M., Zondi, S., Mthembu, N., Mullick, S., (2004). *Involving Men in Maternity Care: South Africa*. University of the Witwatersrand, Department of Obstetrics and Gynecology, Reproductive Health Research Unit. Oct. [57] p.
- Kutcher, S., Ward, B., Hayes, D., Wheeler, K., Brown, F., & Kutcher, J. (1996). *Mental health concerns of Canadian adolescents: a consumer's perspective*. Canadian Journal of Psychiatry, 41 (1): 5–10.
- Lande, R., & Kols, A. (2008). *Vasectomy: Tools for providers*. Baltimore, Maryland: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, Information and Knowledge for Optimal Health.
- Lewis, C., & Lamb, M. (2003). *Fathers: The Research Perspective*. Draft prepared for the International Fatherhood Summit, Oxford, UK.
- Lewis, C., & Lamb, M. (2007). *Understanding fatherhood: A review of recent research*. Joseph Rowntree Foundation, Lancaster University.
- Lindblad, B. (2003). *Men and Boys Can Make a Difference in the Response to the HIV/AIDS Epidemic*. Expert Group Meeting on "The role of men and boys in achieving gender equality." Brasilia: United Nations.
- Lyra, J. (2002). *Paternidades Adolescentes. Regional Varones adolescentes: Construcción de Identidades de Género en América Latina*. Subjetividades, prácticas, derechos y contextos socioculturales de Chile, 6–8. FLACSO, Chile.
- Marsiglio, W. (1988). *Adolescent male sexuality and heterosexual masculinity: A conceptual model and*

review" in *Journal of Adolescent Research* 3 (3-4): 285-303.

Mathers, B.M., Degenhardt, L., Phillips, B., Wiessing, L., Hickman, M., Strathdee, S.A., Wodak, A., Panda, S., Tyndall, M., Toufik, A., & Mattick, R.P. (2008). *Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review*. *Lancet* 372.

McIntyre, P. (2002). *Adolescent Friendly Health Services: An agenda for change*. Geneva, WHO.

Merzel, C. (2000). *Gender Differences in Health Care Access Indicators in an Urban, Low-Income Community*. In *American Journal of Public Health*, 90 (6): 909-916.

Mullany, M.C., Hindin, M.J., & Becker, S. (2005). *Can women's autonomy impede male involvement in pregnancy health in Katmandu, Nepal?* *Social Science & Medicine*, 61: 1993-2006.

National Health Service (2005). *NHS Maternity Services Quantitative Research* (October), Prepared by TNS System Three for Kate Hawkins, Department of Health, London.

National Center on Fathers and Families (2002). *The Fathering Indicators Framework: A Tool for Quantitative and Qualitative Analysis*. Philadelphia, PA, USA.

Nzioka, C. (2001). *Dealing with the Risks of Unwanted Pregnancy and Sexually Transmitted Infections among Adolescents: Some Experiences from Kenya*. *African Journal of Reproductive Health*, 5 (3): 132-149.

Olavarria, J. (2002). *"Hombres: identidades, relaciones de género y conflictos entre trabajo y familia"*. En: Olavarria, José y Céspedes, C. (2002) *Trabajo y familia: ¿Conciliación? Perspectivas de género*. FLACSO-Chile, SERNAM y Centro de Estudios de la Mujer CEM. Santiago, Chile.

Orji, E.O., Adegbenro, C.O., Moses, O.O., Amos, O.T., & Olanrenwaju, O.A. (2007). *Men's Involvement in Safe Motherhood*. *Journal of the Turkish-German Gynecological Association*, 8 (3): 240-246.

Peacock, D. (2003). *Men as Partners: Promoting Men's Involvement in Care and Support Activities for People Living with HIV/AIDS*. Expert Group Meeting on "The role of men and boys in achieving gender equality." Brasilia, Brazil: United Nations.

Peacock, D., & Levack, A. (2004). *The Men as Partners Program in South Africa: Reaching Men to End Gender-Based Violence and Promote Sexual and*

Reproductive Health. *International Journal of Men's Health*, 3 (3) : 173-188.

Pearson, S. (2003). *"Promoting sexual health services to young men: findings from focus group discussions."* *Journal of Family Planning and Reproductive Health Care*; 29(4): 194-198.

Perkins, H.W., Haines, M.P., & Rice, R. (2005). *Misperceiving the College Drinking Norm and Related Problems: A Nationwide Study of Exposure to Prevention Information, Perceived Norms and Student Alcohol Misuse*. *Journal of Studies on Alcohol*. 66(4):470-478.

Population Council (2001). *The Unfinished Transition: Gender Equity: Sharing the Responsibilities of Parenthood*. A Population Council Issues Paper. Available at: http://www.popcouncil.org/publications/issues_papers/transition_4.html.

Promundo (2006). *Program H Manual*. Rio de Janeiro Brazil: Aliança H.

Pulerwitz, J., Barker, G., (2008). *Measuring attitudes toward gender norms among young men in Brazil: Development and psychometric evaluation of the GEM scale./ Men and Masculinities/*. 10(3): 322-338.

Pylkkänen, E., & Smith, N. (2004). *The Impact of Family-Friendly Policies in Denmark and Sweden on Mothers' Career Interruptions Due to Childbirth*. Bonn, Germany: Institute for the Study of Labor.

Raju, S., & Leonard, A. (2000). *Men as Supportive Partners in Reproductive Health: Moving from Rhetoric to Reality*. New Delhi: Population Council.

Rivers, K., & Aggleton, P. (1998). *Men and the HIV epidemic, Gender and the HIV epidemic*. New York: UNDCP HIV and Development Programme.

Rivers, K., and Aggleton, P. (2002). *Adolescent sexuality, gender and the HIV Epidemic, Gender and the HIV Epidemic*. New York. *UNDP HIV and Development Programme*. Website: www.undp.org/hiv/publication/gender/adolesce.html.

Randolph, W., & Viswanath, K. (2004). *Lessons learned from public health mass media campaigns: marketing health in a crowded media world*. *Annual Review of Public Health*. Vol. 25, pp. 419-437.

Rosenfield, A., Maine, D., & Freedman, L. (2006). *Meeting MDG-5: an impossible dream?* *The Lancet*, 368 (9542): 1133-1135.

Saunders, D.G. (1996). *Feminist-cognitive-behavioral and process-psychodynamic treatments for men who batter: Interactions of abuser traits and treatment model*. *Violence and Victims*, 4: 393-414.

- Scalway, T. (2001). *Young men and HIV: Culture, Poverty and Sexual Risk*. Geneva:UNAIDS/The Panos Institute.
- Sherman, L.W., & Berk, R.A. (1984). *Minneapolis Domestic Violence Experiment*. Washington, DC: Police Foundation.
- Shumbu, G., & Eghtessadi, R. (nd). *Shifting the HIV/AIDS Burden of Care – Involving Men and Boys*. Harare, Zimbabwe: SAFAIDS.
- Silberschmidt, M. (2001). *Disempowerment of men in rural and urban East Africa: Implications for male identity and sexual behavior*. *World Development*, 29: 657–671.
- Sloand, E., & Gebrian, B. (2006). *Fathers Clubs to Improve Child Health in Rural Haiti*. *Public Health Nursing*, 23 (1): 46–51.
- Solórzano, I. et al. (2006). *“Positive impact of an HIV prevention communication for social Change program on youth in Nicaragua.”* Global Health Council 2006, Washington, DC, United States, 30 May–June 2. Available at: http://www.globalhealth.org/images/pdf/conf_2006/presentations/a1_pulerwitz.pdf, accessed 2 April 2007
- Spink, G. (2009). *Women, HIV and AIDS*. AVERT. Available at: <http://www.avert.org/women.htm>
- Straus, M.A. (1990). *Social stress and marital violence in a national sample of American families*. In Straus MA & Gelles RJ (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families*, pp. 181–201. New Brunswick, NJ: Transaction.
- Straus, M.A., Gelles, R.J., & Steinmetz, S.K. (1980). *Behind Closed Doors: Violence in the American Family*. Garden City, NY: Doubleday, Anchor Press.
- Travassos, C., Viacava, F., Pinheiro, R., & Brito, A. (2002). *Utilização dos serviços de saúde no Brasil: gênero, características familiares e condição social*. *Pan American Journal of Public Health*, 11 (5/6), 365–373.
- UNAIDS (2000). *Men and AIDS – a gendered approach*. *World AIDS Campaign*. Geneva, Switzerland.
- UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS (nd). *HIV/AIDS, Gender and Sex Work*. Geneva Switzerland: UNAIDS.
- UNAIDS (2008). *2008 Report on the Global AIDS Epidemic*. Geneva, Switzerland: UNAIDS.
- UNAIDS (2009). *UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People*. Geneva, Switzerland. UNAIDS
- United Nations Commission on the Status of Women (2007). *The role of men and boys in achieving gender equality*. New York: United Nations Commission on the Status of Women.
- UNFPA (2000). *“Partnering: A New Approach to Sexual and Reproductive Health.”* Technical Paper No. 3. New York: UNFPA.
- UNFPA (2003). *Preventing HIV/AIDS Among Adolescents Through Integrated Communication Programming*. New York: UNFPA. Accessed on November 30, 2004. Available at: http://www.unfpa.org/upload/lib_pub_file/224_filename_hiv_adolescents02.pdf
- UNFPA (2003). *It Takes 2: Partnering with Men in Reproductive and Sexual Health*. New York: UNFPA.
- UNFPA (2004). *Tool Number 2: Defining Evaluation. Programme Manager’s Planning Monitoring & Evaluation Toolkit*. New York: UNFPA.
- UNFPA (2005). *Reproductive Health Fact Sheet*. State of the World Population 2005: Journalists’ Press Kit. New York: UNFPA.
- UNFPA (2008). *UNFPA Strategy and Framework for Action to Addressing Gender-based Violence 2008–2011*. Gender, Human Rights and Culture Branch. New York: UNFPA.
- UNFPA (n.d.). *Obstetric Fistula in Brief*. New York: UNFPA. Available at: <http://www.endfistula.org/index.htm#>
- United Nations (1993). *Declaration on the Elimination of Violence against Women*. New York: United Nations.
- United Nations (2000). *Security Council Resolution 1325*. New York: United Nations.
- United Nations (2008). *The Millennium Development Goals Report*. New York: United Nations.
- UN Millennium Project (2006). *Sexual and Reproductive Health Report*. UN Millennium Project. New York: United Nations.
- Velzeboer, M., Ellsberg, M., Clavel Arcars, C., & García-Moreno, C. (2002). *Violence Against Women: The Health Sector Responds*. Washington DC: PAHO.
- Watson, B. (1992). *Young Unwed Fathers Pilot Project: Initial Implementation Report*. Philadelphia, PA: Public Private Ventures.

Wiederman, M. (1997). *"The truth must be in here somewhere: Examining the gender discrepancy in selfreported lifetime number of sex partners"*. Journal of Sex Research, 1559–8519, Volume 34, Issue 4: 375 – 386.

World Health Organization (2000). *World Health Report 2000*. Geneva: World Health Organization

World Health Organization (2004) *Global Status Report: Alcohol Policy*. World Health Organization, Department of Mental Health and Substance Abuse, Geneva.

Yang, X., Derlega, V., & Luo, H. (n.d.). *Temporary migration and HIV vulnerability in China*. Findings from a comparative research. Norfolk, Virginia: Old Dominion University.